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ABSTRACT

This publication is designed to assist in the development of therapeutic recreation services in the community and may also be used in the preparation of procedural manuals or risk management plans. Therapeutic recreation is defined as the process of assessment, planning, implementation, and evaluation, applied through a helping relationship to improve functional behaviors and enhance leisure function commensurate with each participant's ability level. The sequence of the text reflects the order to follow when either initiating or redesigning services and is organized into six parts: (1) assessment; (2) demographic information, functioning characteristics, and needs of persons with disabilities; (3) program planning; (4) program operation; (5) implementation; and (6) evaluation. Each part includes an introduction, a summary, a list of key terms, training experiences and study questions, and references. The document concludes with four appendixes: "Assessment and Evaluation Instruments and Resources"; "Accessibility Survey List"; "Integration Planning and Evaluation Documents"; and "Sample Volunteer Manual Contents." (LL)

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Designing Therapeutic Recreation Programs in the Community

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Designing Therapeutic Recreation Programs in the Community

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Sponsored by the
American Association for Leisure and Recreation

an association of the
American Alliance for Health, Physical
Education, Recreation and Dance

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INTRODUCTION

Legislative and legal directives of the 1960s and 1970s fostered the development of community services for persons with disabilities. This impetus was followed during the 1980s by legislation which focused on integrated community living and vocational placements. On July 26, 1990, President George Bush signed into law PL 101-336, Americans with Disabilities Act of 1990, which prohibited discrimination against individuals with disabilities in employment, public services and transportation, public accommodations, and telecommunication services. By January 26, 1992, individuals with disabilities are to have access to state and local government sponsored services, programs, or activities including leisure. This law provided further impetus to facilitate integrative and transitional services.

Several additional factors contributed to intensified integration efforts. Federally supported services and monies to assure the participation of persons with disabilities became less and less available to state and local agencies. Also, an increasing number of persons with disabilities were either returning to the community following traumatic injury, illness, or long-term placement or remaining in the community rather than seeking residential or institutional placements. While the cost of health care skyrocketed, private insurance reimbursements decreased contributing to shorter hospital stays and an increased focus on out-patient services. Additionally, policy statements of public leisure service agencies increasingly began to recognize the acquisition and development of leisure and leisure-related skills by all citizens as fundamental agency goals. Consequently, therapeutic recreators working in clinical, residential, and community service settings became advocates for the design of recreation programs, integrative opportunities, and transitional services. Professionals and individuals with disabilities perceive integration and the planning of age appropriate alternative leisure services as everyone's responsibility while acknowledging the continued need to influence attitudes and beliefs through education and training.

This text is designed to aid in the development of therapeutic recreation services in the community. The sequence of the text reflects the order to follow when either initiating or redesigning services. The process of preparing to offer recreation to persons in the community with disabilities is outlined in four phases (assessment, planning, implementation, and evaluation) applied by practitioners and educators as they actually design or teach students how to design programs for all persons.

Information and exhibits are drawn from actual experiences, participants, and operating documents. The content is broad in scope yet specific enough to be used in the preparation of, for example, a procedural manual or risk management plan.

Therapeutic recreation is defined as the process of assessment, planning, implementation, and evaluation applied through a helping relationship to improve functional behaviors and enhance leisure functioning commensurate with each participant's ability level. This philosophy realizes that therapeutic recreation is determined by its purpose rather than by a particular setting or clientele. Thus, the term "participant" refers to the client, consumer, or patient participating in therapeutic recreation; "public" refers not only to tax-supported agencies but also to private and nonprofit human service agencies; and "leader" refers to persons with or without specific credentials in therapeutic recreation.

The text is designed using two concepts as guiding principles. The first is the process followed as community master plans are developed. The second is the implementation of the therapeutic recreation process to design specific programs. A community master plan is a five-year, or longer, action plan that identifies all participants, and their current and future service needs including leisure. This written document encompasses all aspects of community planning and is used by administrators to organize resources, time, and people to assure services appropriate to all citizens. This plan may delineate recreation and therapeutic recreation in one particular section or may integrate provisions for therapeutic recreation throughout the narrative.

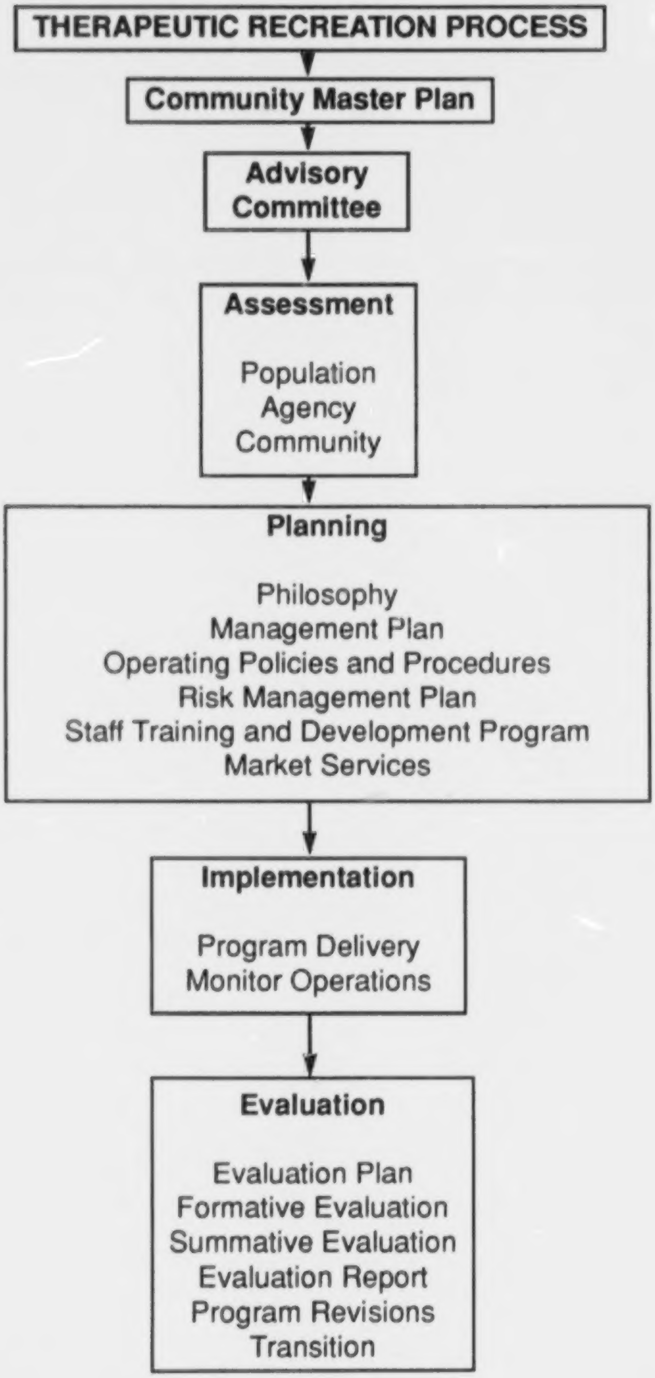
The organization of master plans varies from community to community, yet their content is similar. Shown in Exhibit 1-1 is the content outline of a model community master plan. 1) The Needs Assessment section contains data about the persons living in the community, the availability of services and resources, and features unique to the community. 2) Demand Analysis is undertaken to determine current and future needs of the citizens, expressed and actual participation rates, successful programs, and anticipated interest areas. 3) A Standards Analysis occurs when the planner studies governmental and professional mandates and recommendations to ascertain existing service guidelines. The programs and services currently being offered are compared to the guidelines to determine their appropriateness. 4) The Financial Analysis identifies the revenues, expenditures, and fiscal resources available in the community as well as the willingness of the community to financially support therapeutic recreation. 5) The Action Plan contains the proposed steps to be initiated in the delivery of leisure services. Services are prioritized. Timelines and costs are projected. An evaluation plan is prepared for the entire master plan.

The second concept upon which this text is designed is the implementation of the therapeutic recreation process. Each section of this text contains information about one of the four phases (assessment, planning, implementation, and evaluation) of the design process. Each phase must accomplish specific results before the tasks of the next phase can be undertaken. The use of these four phases results in a program intended to achieve measurable participant outcomes. Systematic program development relies upon an updated community master plan to provide the data base, participant and program information, resource descriptors, and a plan of action. This text is organized according to this four phase approach (see Exhibit 1-2).

Exhibit 1 - 1
COMMUNITY MASTER PLAN OUTLINE

1. Needs Assessment
    - a. Population Analysis - such as demographics and trends
    - b. Supply Analysis - such as agency and non-agency supplied leisure resources, facilities, programs, personnel, and finances
    - c. Sociological and Geographical Features - such as accessibility awareness, transportation needs, and intra/inter agency cooperation
2. Demand Analysis
    - a. Participation Characteristics
    - b. Program Analysis
    - c. Tradition and Trends
    - d. Consumer Needs
3. Standards Analysis
    - a. Federal, State, Local, and Agency Standards
    - b. Agency Operating Policies
    - c. Recreation and Therapeutic Recreation Standards
    - d. Current and Future Development Standards
    - e. Comparison of Supply with Standards
4. Financial Analysis
    - a. Tradition and Trends
    - b. Existing and Anticipated Expenditures and Revenues
    - c. Funding Master Plan Recommendations
5. Action Plan
    - a. Prioritized Service Development Recommendations for Management, Programs, Personnel, and Resources
    - b. Timeline and Cost Projections
    - c. Evaluation Plan

Exhibit 1 - 2


THERAPEUTIC RECREATION PROCESS
Community Master Plan
Advisory Committee
Assessment
Population
Agency
Community
Planning
Philosophy
Management Plan
Operating Policies and Procedures
Risk Management Plan
Staff Training and Development Program
Market Services
Implementation
Program Delivery
Monitor Operations
Evaluation
Evaluation Plan
Formative Evaluation
Summative Evaluation
Evaluation Report
Program Revisions
Transition

PART I

ASSESSMENT

INTRODUCTION

This portion of the publication presents information on the first phase in program design, assessment. During this phase data are collected on the participants, the agency, and the community in order to establish the scope or range of resources, needs, and existing liabilities. The assessment data are used to determine potential service parameters and to justify current and future decision-making. The sections within this part present information on the assessment process, the advisory committee, the population, the agency, and the community. Additionally, information on assessment resources, how to assess or assessment techniques, and instruments used to assess participants are presented in Appendix A.

SECTION A: ASSESSMENT PROCESS AND TECHNIQUES

Assessment is the process of identifying and gathering information about the community, the agency, and the population being served with the intent of making appropriate programming decisions. This process enables objective decisions to be made about replacing or deleting current services, altering existing services, designing new services, or remaining status quo. The assessment takes into account not only what is presently available but what options could be made available. Completion of a needs assessment establishes the scope of service or programmatic boundaries as determined by the following: available and anticipated fiscal, personnel, and supportive supplies and resources; natural community features and demographics; imposing standards, governing ordinances, and historical mandates; and participant patterns, needs, and trends. Three techniques are used to gather assessment data: observation, interview, and written response. Visiting a park and completing a "time-sampling" or watching a participant in a play lab represent observational techniques. Door-to-door canvassing, phone interviews, or preliminary discussion with parents are forms of oral or interview data collection. Paper-pencil checklists, questionnaires, or standardized instruments are examples of the written assessment technique.

The use of these assessment techniques is influenced by several factors:

1. Politics or protocol, such as unwritten codes of conduct, determine when data are collected, who collects them, to whom are they reported, and how they are used. To illustrate, a supervisor may believe that participants would better report their program outcomes to a senior staff member than to an entry-level employee. Likewise, a certain member of the advisory committee may be given access to statistics from the United Way more easily than would a staff member.

2. Support from the community and the nature of the people within the community influence what is assessed and to whom results are reported. Persons with emotional disabilities may not be well received because of the public's lack of understanding. If the results of the assessment indicate a need for leisure services with this population, community decision-makers may hesitate to use the data to develop appropriate programs.

3. The availability of personnel with expertise, finances, time, and supportive resources tends to enhance or detract from the assessment process and to influence which techniques are selected. Urgency to initiate services with persons with disabilities may limit the time devoted to data collection. Historically, the lack of skilled personnel and instruments in the leisure field has limited therapeutic recreation assessments.

4. Professional regulations and codes, legislative and legal directives, and standards and statistical coding procedures at the federal, state, and local levels determine when assessment occurs, how information is categorized, and how the results are reported. Standards in state and federal laws identify the categories of persons with disabilities and the kind of assessment data that must be collected with each. Standards of practice in therapeutic recreation imply that active treatment is needed for persons with disabilities.

5. Another major influence on selection of assessment techniques is consideration of how the data will be presented. A chart or graph may be more effective than words. In an agency's budget politics, facts and figures have more influence than would a naturalistic observation report describing the need for independent community living skills. The demographic makeup of the audience receiving a report greatly influences the type of assessment instruments selected and the language used to report results. Agency professionals expect peers to employ proven techniques to collect data, whereas advisory committee members anticipate consumer needs to be reflected in results reported in lay language.

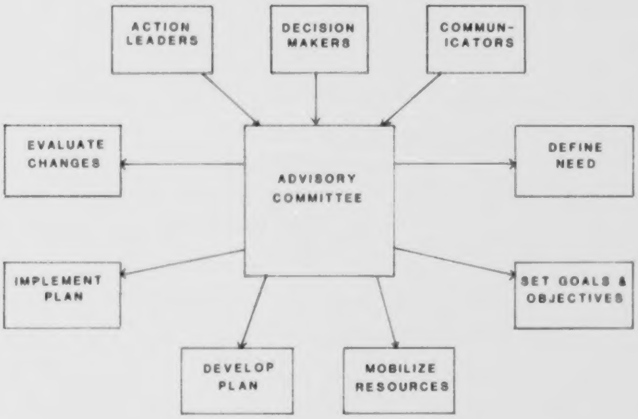
6. Ultimately the technique selected depends upon the purpose of the assessment and the respondents' capabilities. Written techniques are often less time-consuming to administer but depend upon the respondent being able to read, write, and comprehend the meaning of words. The interview technique, although time-consuming, provides first-hand information by allowing the interviewer to clarify meanings of responses. The assumption is that the respondent is able to verbalize or otherwise make known personal needs, but with some participants this is not possible. Observation also is used to collect data first-hand. This technique relies on the observer's objectivity and is also time-consuming; yet, this technique may be the most accurate to use with certain participants when establishing a data baseline.

The assessment data are collected on the entire community and the influences surrounding everyone's leisure behavior. Residents may seek leisure in neighboring geographic areas; parents may use a summer or year-round camp or school in another area of the community or state; and unique popular recreation resources may only be available an hour's drive from town. The assessment process should encompass all the following factors: recreation areas, programs, and facilities; leadership, from elected officials to community volunteers; financial resources; sociological and geographic data; attitudinal and program accessibility; traditions and trends; and standards and regulations or codes of performance from government agencies and professional entities. This process is cyclical in nature. Information is collected over time as programs are offered and resources become available. With each new session or season data obtained from the previous time period provide feedback or input for decisions. Data may also be gathered through luncheon meetings, agency visits, library study, and discussion with community planners and government statisticians. Input from key community representatives and consumers is critical to the entire program planning process. To enable this to occur consistently, the formation of an advisory group (committee, council, board) is an essential preliminary management task.

SECTION B: ADVISORY COMMITTEE: THE COMMUNITY ACTION PROCESS

From the community comes the justification to provide leisure to all citizens. A program formulated with the assistance of a therapeutic recreation advisory committee is self-advocating. Those who have had input into the definition of community needs, allocation of resources, and determination of funding priorities are more likely to support the manager when hardline decisions must be made. An advisory committee links the therapeutic recreator to the community. The therapeutic recreator relies heavily on key lay persons to interpret the meaning of and to justify the need for therapeutic recreation to the social leaders of a community. Selection of key persons enables input into the planning process (see Exhibit 2-1). A major responsibility of the therapeutic recreator is to facilitate, monitor, and define the parameters of this committee's activities.

Exhibit 2-1
THE COMMUNITY ACTION PROCESS



Support from leaders in a community is key to the development, delivery, and results of therapeutic recreation. Key persons in the community social fiber are categorized as action leaders, decision-makers, and communicators. Action leaders are persons in positions from which change can be instigated. These persons either understand the need to develop therapeutic recreation or are in positions to design the justification or support for such service needs. Personnel within the public agency, professional staff in related agencies, such as ARC (Association for Retarded Citizens) or UCP (United Cerebral Palsy Association), and therapeutic recreators from neighboring communities are potential action leaders. Decision-makers legitimize the service. Members of the park board, city council, and professional staff within the political system determine, for example, monies allotted to services, timing of available positions, and which programs are given priority. Communicators bring to the public information about therapeutic recreation. A prime responsibility is to educate the community, the action leaders, and decision-makers to the leisure needs of persons with disabilities. These persons must therefore be committed to therapeutic recreation and be accepted by the influential power strata of the community. These persons are prime candidates for the advisory committee. Physicians, lawyers, education personnel, members of Rotary or Junior League, owners of private businesses, and consumer advocates represent key communicators.

The advisory committee serves several key functions:

1. Identifying community needs.
2. Accessing resources and ideas, especially fundraising, innovative programming, and supportive resources, such as media and transportation.
3. Educating the community at large to concerns, such as accessibility, legislation, and family or primary caregiver needs.
4. Serving as liaisons among the action leaders, decision-makers, consumers, and program staff.
5. Serving as the primary "PR" avenue by word-of-mouth contacts with selected community leaders, and exemplary attendance at selected special events.
6. Making recommendations on program guidelines and on operating policies and procedures.
7. Lending noted "expertise" or credibility to staff and administrative directives.

Composition of the committee is critical and delicate. The responsibilities of the committee members should be clearly stated in the bylaws which should include operating directives from the park board, city manager's office, or board of directors (see Exhibit 2-2). Professional staff should attend the advisory committee meetings so they are aware of committee members' interests and actions. Continuous in-service training of committee members is used to apprise them of their advisory role with respect to agency functions. Each geographic area, ethnic group, consumer population, and any other characteristic unique to the community should be represented on the committee. Having an odd number of members, from seven to eleven, is functional for decision-making and for organizing necessary subcommittees. Advisory committee members should be willing to attend monthly meetings for at least a one year term. Meetings should be conducted according to Robert's Rules of Order with officers elected accordingly. Fiscal accounting should follow agency directives.

Staff members must be made aware of the social and/or political significance of each committee member. Likewise, advisory committee members should be apprised of staff responsibilities, chain of command, agency goals, consumer needs, and significant agency functions. The properly selected and managed advisory committee serves as the "pulse" of the community and a feedback system to the professional staff.

Exhibit 2-2
ADVISORY COMMITTEES

The advisory committee is a liaison body working between the board and the community. Its purpose is to establish lines of communication between the citizens of the community, facility leaders, and administration of the department to the end that it will:

1. Provide assistance in the discovery and use of all local resources which can be of value to the community recreation program.
2. Help in relating the recreation program to the services and programs of other agencies and organizations in the community.
3. Assist in finding and using recreation leadership, both professional and voluntary, which always exists to some extent in any area.
4. Keep leaders advised of community interests, attitudes, and customs and assist in planning the program for the community in general and for special groups.
5. Assist in training recreation personnel in specific skills.
6. Offer guidance in methods of procedure.
7. Help to create and develop public opinion in favor of the program.
8. Assist in raising the budget and providing supplementary funds.
9. Develop an understanding and a wider public acceptance of higher standards in personnel, facilities, program, and finance.
10. Act as a board of appeals and medium for screening community suggestions and criticism.
11. Receive and circulate printed literature of all types on community recreation.
12. Sponsor special community recreation events and projects.
13. Promote neighborliness among residents.

SECTION C: POPULATION ANALYSIS

A population analysis identifies three types of information concerning the characteristics of the residents within the service area as they currently exist and as they may exist in the future. These three are: 1) demographics; 2) participant functioning characteristics; and 3) participant needs, interests, and skills. Data are gathered using either staff-prepared tools or standardized instruments.

Demographic data are gathered from documents of the U.S. Bureau of Census, Bureau of Vital Statistics, Chamber of Commerce, and local, county, and state planning authorities. Also gathered is information on the functioning characteristics, leisure resources, needs, interests, and skills of residents. These data reveal preferences, patterns, levels of support for, and specifically, who desires therapeutic recreation.

This information is gathered prior to, during, and following program participation from persons with disabilities, significant others, peer professionals, educators, physicians, employers, and social workers. Library research and networking with social service agencies, advisory committees, and other professionals via formal and informal meetings, conversations, and interviews enhance the data base while creating further potential for cooperative programming.

Study of the data collected during the population analysis reveals potential leisure service users throughout the community. Persons with more frequently occurring disabilities, such as mental, orthopedic, speech, or specific learning disabilities, may have access to more geographically convenient leisure services than such low incidence populations as the deaf, visually impaired, multihandicapped, and the severely emotionally disturbed. Population data analysis provides objective justification on where, for whom, and how much leisure services are necessary to meet the leisure needs of all residents.

Demographics

Population descriptors of a community include the following characteristics: age; gender; race; education; vocation; income; special characteristics, such as persons with activity limitations; mobility; number and makeup of households; and population growth, distribution, density, and projections. Study of these data reveals median income, concentrations of specific age groups, geographic location of populations, community growth areas, stability of residents, employment patterns, and family support networks.

Interpretation of these data enables planners to objectively present which age groups and populations need improved access to leisure experiences; where present and future programs ought to be located; how fees and charges might be set up; and who needs additional information to better understand why recreation and therapeutic recreation are necessary community services. The information obtained from analysis of the data should be made available to the professional staff and to the advisory committee during the annual budget process and if concerned citizens present their vested interests or demands.

Demographics and trends are developed from existing documents found in planning offices, libraries, the court house, and agency feasibility studies. The first step is to collect key population records and documents including:

1. U.S. Bureau of Census general population characteristics and the statistical abstract of the United States.
2. State, county, and city land use plans from local or regional zoning and planning commissions.
3. Health and disability statistics from state and local social service departments.
4. Business and economics reviews from the Department of Commerce, Chamber of Commerce, or state universities.
5. Existing agency and governmental annual reports and needs surveys from branches of the government and other social service organizations, such as the Association for Retarded Citizens, United Cerebral Palsy Association, or Easter Seal Society.

The next step is to prepare tables, charts, or graphs to display the data abstracted from the above listed reports (see Exhibit 2-3). From these exhibits, conclusions are drawn and reported in narrative form. The planner uses the exhibits and the narrative to determine where the people are located, what services are needed, and the resources available to provide programs. To illustrate, the sample data in Exhibit 2-3 show that the likely recreation service needs are in subareas I and III where population increases have or will occur. The data for subarea II indicate no increase in population, suggesting resources may not need to be increased in this geographic area.

Participant Functioning Characteristics

The therapeutic recreator analyzes the demographic data in greater detail to determine participants' developmental or functional levels. Mental, physical, social, emotional, and self-help skills are assessed to identify potential performance levels and services required to enhance community leisure participation. To assure success, participants must display adequate skill levels in the following behaviors: expressive and receptive communication; mobility, fitness, coordination, and ambulation; reasoning, skill transfer, and generalization; personal interactions and social exchanges; reality orientation; behavioral control and mood expression; protective assertiveness or self-defense; and self-care or activities of daily living (ADL).

The therapeutic recreator must also look beyond the participant to the support system or the immediate caregivers. These persons may or may not be able to provide resources required for participation. Money, transportation, time, resourcefulness of significant others, and having available prosthetic, orthopedic, and recreation equipment influence the person's degree of leisure development.

Functional levels are ascertained through review of hospital, school, and social service reports and from completion of registration forms and staff-administered invento-

Exhibit 2-3
DEMOGRAPHIC CHARACTERISTICS

According to the U.S. Bureau of the Census, in 1980, 5,712 people lived in Subarea I, 3,878 people lived in Subarea II, and 6,167 people lived in Subarea III for a total study area population of 15,757 people.

Estimated Population

POPULATION	1980	1985	% increase over 1980	2000	% increase over 1985
Subarea I	5712	7306	28%	7567	3%
Subarea II	3878	3878	0%	3878	0%
Subarea III	6167	6780	10%	7193	6%
Study Area	15757	17964	14%	18638	4%

Summary

- Between 1980 and 1985 the study area's population increased slightly, about 14%, from 15,757 to 17,964 people.
- Between 1980 and 1985 Subarea I showed the largest growth rate, 28%.
- Between 1980 and 1985 Subarea II showed no population increase.
- The projected growth rate of Subarea III for the year 2000 is a 6% increase over the 1985 population figure.

ries and surveys. Examples of useful information include scores from the AAMD Adaptive Behavior Scale, Denver Developmental Screening Test, Southern California Perceptual-Motor Tests, Goodenough-Harris Drawing Test, Peabody Picture Vocabulary Test, Stanford-Binet Intelligence Scale, Wechsler Intelligence Scale for Children, Purdue Perceptual-Motor Survey, or Illinois Test of Psycholinguistic Abilities. These data may be made available from the school system by the social worker assisting with community placements.

Registration forms completed by either the family or the participant or provided by personnel representing the referral agency provide a second source of information. Respondents may be requested to identify a participant's disability and functional level by selecting a ranked descriptor characteristic of the participant's general behavior (see Exhibit 2-4 and Appendix A). Additional information which is helpful in determining the participant's functional level includes: physician recommendations and list of limitations, medication type and dosage, dietary needs and restrictions, assistive devices used, such as wheelchair or shunt, behavioral management techniques found successful, and the presence of seizures, allergies, heart or blood conditions, and atlantoaxial condition. If participants have had leisure experiences, their skill levels may be increased. Therefore, informa-

Exhibit 2-4
CINCINNATI RECREATION COMMISSION, DIVISION OF THERAPEUTIC RECREATION, SKILL LEVEL CONTINUUM

LEVEL I
Participants in need of one to one to two staff to participant ratio for personal needs and program activities. Level I participants are in need of development of basic socialization and communication skills, self-help and motor coordination skills. Activities for Level I individuals should stress development of basic socialization, sensory-motor, self-help, and motor coordination skills.

LEVEL II
Participants who are able to function in group situations and with minimal assistance can communicate and manage personal needs. Level II participants have begun to refine basic motor and self-help skills. Activities for Level II participants should stress group socialization and refinement and gross motor skills for higher level recreation activities.

LEVEL III
Participants who possess the skills necessary to learn high level recreation activities. Level III participants can communicate or manage personal needs with little or no assistance and have a high degree of development in socialization and motor skills. Activities for Level III participants should stress refinement of skills for high level recreation activities and integrative programming.

L.I.N.K.
Leisure Integration NetworK
Participants who possess the skills necessary to participate in integrative recreation activities, with minimal specialized instruction or assistance.

LEVEL IV
Independent leisure functioning

tion about the available home recreation resources, such as caregiver support and follow-through, money, transportation, equipment and activity areas, aids in determining appropriate placements.

Staff administered inventories, surveys, questionnaires, observations, and interviews provide a third source of functional level data. Therapeutic recreators may opt to use existing instruments or develop their own to generate this information. Standardized instruments that are available include, but are not limited to: LDB (Leisure Diagnostic Battery), RBI (Recreation Behavior Inventory), and CERT (Comprehensive Evaluation in Recreation Therapy). Also available are several leisure interest, values, and attitude scales, such as the LAB (Leisure Activities Blank), LII (Leisure Interest Inventory), Mirenda Leisure Interest Finder, SLIP (Self-Leisure Interest Profile), Leisure Attitude Scale, the Leisure Satisfaction Scale, and Leisurescope. To accommodate the requirements of accrediting bodies and risk managers, certain terminology must appear in the body of the assessment tool. These terms are described in regulatory guides available from agencies, such as JCAHCO (Joint Commission on Accreditation of Health Care Organizations). Consequently, to comply with such standards and to efficiently complete the assessment phase of programming, staff often elect to prepare their own tools which encompass the three types of participant data: 1) demographics, 2) functioning characteristics, and 3) leisure needs, interests, and skills (considered in the next section). Refer to Appendix A for assessment information.

Developmental scales and growth charts present sequential behavioral characteristics in mental, physical, social, emotional, and self-help skills. An outcome of the assessment process is determination of the participant's functional level in each of these areas. These data may be collected before the program commences by interviewing participants or significant others, by requiring participants and significant others to complete fundamental skill inventories, or by observing participants during pre-arranged activity assessment periods. The instrument format appears as a checklist or ranking of behavioral skills in each developmental area.

Participant Needs, Interests, and Skills

With persons with disabilities, factors extraneous to their stated or perceived likes and dislikes influence their leisure patterns. Commonly, inordinate amounts of time are spent in the home recreating with family members, who, in essence are relinquishing their leisure time to accommodate the needs of the "special" family member. Thus, one consideration is the previous and current leisure pattern of the person with a disability and their family. How frequently, with whom, what type of activities, and where and when does leisure occur? And are these reflective of the needs of the special family member or of the entire family?

The attitudes of the participant, the family, and friends are reflected in a willingness to allow money, time, and resources to be made available for leisure activities. The "home" has expectations and values resulting from their status, financial ability, and cultural background. Family members' interests, extrinsic rewards, or feelings of security or need for attention may actually be stronger incentives than personal needs. Participation in leisure activities may satisfy dual needs — those of the family and friends as well as of the participant.

Certain skills appear more critical to community placement. Independent pursuit of leisure requires the ability to remain on task, solve problems, and make decisions in structured and unstructured programs, such as those found in leisure education classes. Data on the participant's ability to receive directions, attend to and follow through, organize, associate decisions with tasks, and make choices as tasks are undertaken must be collected. The level of skill in these areas defines the amount of behavioral intervention necessary prior to, for instance, placement in integrated recreation experiences.

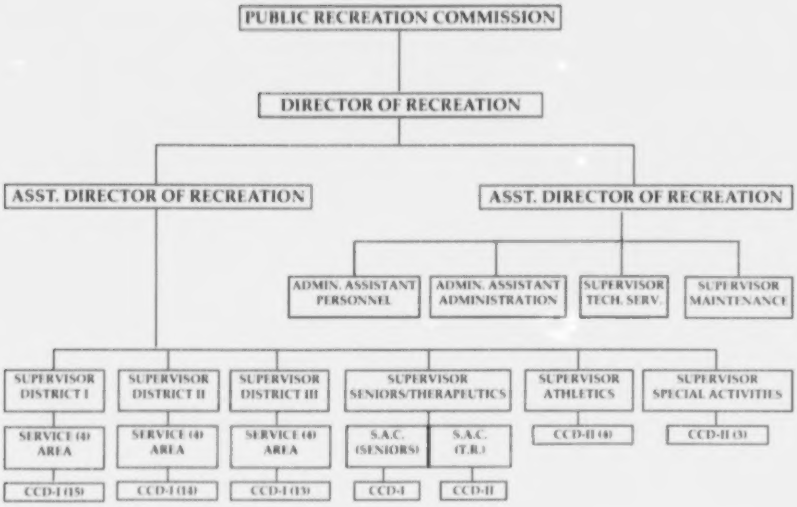
Data about leisure needs, interests, and skills which were gathered during the third step are organized into five categories: personal-social behaviors, leisure history, interests, motivation, and lifestyle. By observation, interview, or written response, information on the participant's comfort and ability to negotiate and orient to social experiences, to cooperate or compete, to function independently, to follow directions, to respond to others, to complete self-defined tasks, and to prepare self for leisure experiences is gathered. Performance in this area greatly influences access to leisure and acceptance in the community. Past and present leisure patterns and interests reveal potential preferences. As previously mentioned, the motivations of persons with disabilities are likely to be influenced not only by their needs but also by the people around them. Thus, assessment concerns include "why" and "when" persons with disabilities and significant caregivers participate in certain experiences during particular time frames.

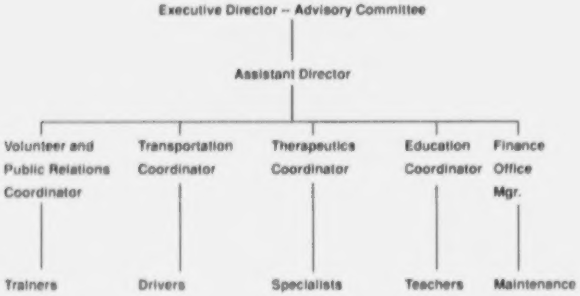
SECTION D: AGENCY ANALYSIS

An agency analysis is undertaken during the assessment process to determine the resources, assets, and potential limitations of the system in which therapeutic programs are offered. Therapeutic programs may exist as a specialized option in public recreation services, for example, therapeutics may be grouped in the special services division along with seniors, pre-school, and volunteers. Or, as with nonprofit agencies, therapeutic programs may be organized as autonomous units having parity with other agency services, such as vocational placement (see Exhibit 2-5). The therapeutic recreator examines the structure and operation of the agency to ascertain the posture and commitment of the agency toward therapeutic programs and the resources available or needed to enhance or remodel current offerings or create new services.

This data collection is an ongoing process; it is initiated with the development of the master plan and continues as session, seasonal, and yearly program revisions occur. Information is gathered from such documents as annual reports, budget statements, personnel and operational manuals, charter and bylaws, board or advisory committee minutes, and reports on personnel, programs, participants, and operating policies and procedures. Key questions to be answered include: 1) What is the demand and supply of therapeutic programs and how does this compare to the total agency service pattern? 2) What resources have been or will be available to these programs and how does this demand relate to the total agency resource pool? 3) What intra-agency networking exists or could exist to allow access to supportive resources, such as transportation, public relations, and funding? 4) Are there standards under which the agency currently operates that apply to therapeutic programming, such as Section 504 criteria, land use patterns, fees/charges, and civil service regulations?

Exhibit 2-5


PUBLIC RECREATION COMMISSION
DIRECTOR OF RECREATION
ASST. DIRECTOR OF RECREATION
ASST. DIRECTOR OF RECREATION
ADMIN. ASSISTANT PERSONNEL
ADMIN. ASSISTANT ADMINISTRATION
SUPERVISOR TECH. SERV.
SUPERVISOR MAINTENANCE
SUPERVISOR DISTRICT I
SUPERVISOR DISTRICT II
SUPERVISOR DISTRICT III
SUPERVISOR SENIORS/THERAPEUTICS
SUPERVISOR ATHLETICS
SUPERVISOR SPECIAL ACTIVITIES
SERVICE (4) AREA
SERVICE (4) AREA
SERVICE (4) AREA
S.A.C. (SENIORS)
S.A.C. (T.R.)
CCD-II (4)
CCD-II (3)
CCD-I (15)
CCD-I (14)
CCD-I (13)
CCD-I
CCD-II


Executive Director -- Advisory Committee
Assistant Director
Volunteer and Public Relations Coordinator
Transportation Coordinator
Therapeutics Coordinator
Education Coordinator
Finance Office Mgr.
Trainers
Drivers
Specialists
Teachers
Maintenance

Program Demand and Supply

What therapeutic programs are currently being offered or supplied? Are the programs now provided adequate and appropriate to the demand? Through an inventory of current agency offerings, a determination may be made of what programs are offered, which participants attend, and when and where the programs are presented. These data are compared to input from participants, significant others, and staff who identify those experiences that are most preferred or requested and which best satisfy individual participant needs. Questionnaires administered to all agency staff, advisory committee members, parents, participants, school and vocational personnel, and health and social service professionals supply an accurate picture of what is currently offered and what could be offered by the agency.

Tradition and Trends

A study of the agency's history may explain the status of certain programs. The special interests of donors or early developers may have established program and facility priorities. Facility construction and area dedication in the name of an affluent board member are common occurrences. Significant personal experiences or preferences of administrators or key agency supporters may have contributed to agency focus on certain programs, such as an aquatic or therapeutic program for participants with a specific disability.

Sociological and technological trends have influenced community recreation. Deinstitutionalization was an initial impetus to the development of community "therapeutic recreation." Emphasis on vocational training, transitional planning and integration, outpatient care, wellness programs, and the availability of anticonvulsant and psychotropic drugs have also indirectly supported community-based services. The citizenry of today are assuming a more active role in the identification of their social and health needs. Accountability and documentation are viewed not only as essential cost-containment measures, but also as elements of risk management and quality assurance. Scientific advances, such as the computer and artificial limbs and organs, facilitate program access.

The therapeutic recreator becomes aware of these agency influences by reviewing and observing department goals and agency policy statements, reading professional publications, attending workshops and conferences, and monitoring data from other community agencies. Review of past agency programs and schedules indicates the direction of change. Awareness of trends in the larger arena of therapeutic recreation, such as cost containment, quality assurance, and risk management, enables the therapeutic professional to assume a proactive role in program design.

Facilities and Areas

The size of the community, the funds available, and the recreational interests of consumers influence the number and types of recreation facilities and areas. Maps secured from the Planning Division or the Chamber of Commerce show local and regional recreation resources which are available for use by community residents. The documents should note whether the lands are developed or undeveloped, public or private, the type of zoning, and plans for future use, such as those proposed for acquisition. Structures should be identified by type, location, condition, accessibility, size, use, floor plans, and annual operating costs. Where facilities and areas are mutually used, the ownership, fees, and contractual arrangements should be noted.

The physical condition of the facilities and areas influences public and participant attitude toward programs. People tend to support and respect well-kept facilities; they show less care and interest in run-down areas. Access to support resources, such as bathrooms, lighted parking lots, and storage areas, also determines patronage. A facility

Exhibit 2-6
FACILITY USE CHART

Please identify the recreation facilities that you utilize for your programs and activities according to:

	Program or Activity Name	Facility Utilized	Space Used in Facility	Period of Time Used	Costs	Accessibility Criteria
ex:	Adapted aquatics	Pool at 100 Swim Drive	Co-ed dressing area and entire pool	Sept-Dec	$25.00 per hr	Parking. Dressing area and pool have ramps & handrails. Toilets are usable.

use chart drawn up by the staff identifies the use made of community and regional resources. This chart gives the staff an overview of present and future program possibilities (see Exhibit 2-6).

Staff and Support Personnel

Agency personnel are program assets as are the citizens on boards and committees. Skills, interests, motivations, attitudes, and special talents of staff, support personnel, and volunteers may be utilized to enhance program depth, quality, and participant involvement. The hobbies and talents of the staff may be used to supplement program offerings; participants and volunteers with specialized leisure skills also serve as program resources.

Information gathered during the population analysis helps to determine the skills and qualifications needed in staff. Of primary concern is their interest, availability, and willingness to acquire needed programming skills. Generalized personnel criteria applicable to staff include:

Programmatic leadership skills, such as aquatics, performing arts, creative arts, outdoors, and fitness
Technical skills, such as sign language, positioning, behavior management, and reality orientation
Ability to access community resources, including volunteer and financial sources
Working knowledge of computers to maintain records and document staff, participant, and program functions
Ability to use the media to market programs
Willingness to assist participants with activities of daily living (ADL), such as toileting and feeding
Ability to manage seizures, distribute medication, administer CPR, and follow proper procedures for diabetic shock or coma

Skills to modify equipment, activity, or participant procedures
Ability to assess consumers and the general public to ascertain attitudes, skill levels, and program needs
Ability to write daily and/or weekly participant and agency program plans and schedules
Ability to carry out transitional plans, effect community-wide networking, and facilitate participant integration
Ability to secure supplies, equipment, and materials and to maintain proper safety and risk management inspections
Ability to conduct advisory committee and neighborhood meetings

A study of the agency staff's histories may reveal specialized education and training or exposure to persons with disabilities through previous experiences. Personal contacts made by staff may lead to unique program opportunities, such as a trip to a museum or a special restaurant. Department employees may have developed specialized skills useful in staff training, such as motivation techniques, evaluation, or report writing. Assessment of all agency staff is essential to assure that no resources are left uncovered.

Attitudes and skills of staff, volunteers, and administrators determine training needs. Acceptance of certain populations, such as the emotionally disturbed, or activities, such as adventure activities, is influenced by a person's knowledge, understanding, and exposure to therapeutic recreation. The organizational structure of an agency determines priorities, roles, and functions of personnel and the interrelationships of programs and employees; for example, the political structure establishes protocol and procedures.

Through past and current program files, information on program leadership is secured. Staff inventories and job descriptions reveal staff capabilities and training needs. Sensitivity and awareness to persons with disabilities may not be discovered by paper-pencil exercises but will be evident through observation, discussion, and simulation experiences held during staff meetings. Administration of an agency awareness survey may be a task undertaken early in the master planning process.

Fiscal Matters

The fiscal resources which have been allotted to therapeutic programs denote the priority given by the agency to this service. Monies available determine the length of the program, the quality of staff, the condition and amount of supplies, equipment and materials, and the types of programs offered. Analysis of the agency's funding base includes study of past, present, and estimated future income sources and expenditures. The primary revenue base of many agencies is comprised of taxes, fees/charges, bond issue monies, revenue-sharing, United Way funds, grants, and contracts. Through the advisory committee, additional monies may be secured from donations, gifts, and fundraising. Staff salaries, utilities, insurance, equipment, and marketing are among the largest expenditures.

To determine past, present, and future revenues and expenditures the therapeutic recreator might consider the following as sources of information:

Agency master plans
The previous five years' year-end fiscal reports
Annual reports
Program reports
Accountant records of revenues and expense ledgers
Facility and supply inventories
Salary scales and reports
Peer agency reports on cost per participant or cost per program
Supply catalogues
Tax records
Advisory committee reports
Daily cash reports
Registration records
Reimbursement schedules from third party payers
Standardized insurance reimbursement scales
Fees/charges plans
Agency objectives and priorities or yearly goals
Bond ratings and reports
Petty cash reports
Monthly budget printouts
Budget forecasts and estimates

Study of budgets from past fiscal years and available budgets from agencies with similar programs supplies information on funding alternatives. The therapeutic recreator must become aware of the politics inherent in the budget process which may be identified when existing budget documents are scrutinized. A responsibility of the therapeutic recreator is to identify key agency staff and governmental leaders and educate them to the needs of persons with disabilities and the importance of financing various options, such as integrated, segregated, or mainstreamed programs. The therapeutic recreator must be aware of the review process followed during budget preparation and be prepared to propose alternative program funding sources, such as sliding fee schedules, cooperative transportation, and scholarship funds.

Supplies, Equipment, and Materials

The amount and the condition of supplies, equipment, and materials influence public and participant attitude toward the program. Activities run as "hand-me-downs" are perceived as having "second-class" values and importance, whereas those in which resources are visibly appropriate and in good working condition reflect quality service delivery. Another factor supportive of the program is the convenience and availability of storage space for supplies, equipment, and materials. The location of the programs and the amount of space allocated to therapeutic services may either enhance or detract from the perceived quality of the services.

Monitoring of the inventory sheets written at the conclusion of each session, season, and year gives a comprehensive picture of equipment and materials. Review of requisition and purchase order forms documents supplies used during the programs. Maintenance of a "gift" list or donor idea list and review of its contents will also reveal program interest areas and alternative avenues to acquire needed resources. One type of equipment needed by therapeutic recreation programs is adaptive and orthopedic equipment, such as "soft" balls and extra wheelchairs. These are used to enable an increased level of participation and to protect the participant's personal equipment from damage resulting from the natural consequences of the activity. By collecting catalogs and comparing price changes from year to year, the programmer is better able to accurately project budget needs.

Transportation, Communication, and Cooperation

The therapeutic recreator is dependent upon resources from the community at large to augment agency resources. Thus, an agency assessment must include a determination of how the agency's resources are used within the community and how the agency uses the resources of the community. Three key areas to study include transportation, communication, and cooperation.

Does the agency own and operate, subcontract for, or lease/rent vehicles? For what purposes are available vehicles used? Are they used to provide transportation from home to the program? Or, does the philosophy of the agency preclude agency-sponsored transportation? Are the vehicles used to support the program activities being offered?

Accessible transportation has been and continues to remain a problematic area with community programs. Studies indicate that agencies tend not to assume this responsibility with the exception of enhancing program offerings, such as field trips and special outings (Smith & Gelvin, 1981). When the therapeutic recreator has determined the agency's status on transportation, options available to the agency from the community must be investigated. The therapeutic recreator should assume a proactive posture and initiate cooperative efforts to explore access to transportation carriers, routes, costs, and hours of operation. This investigation includes such concerns as: Where are activities to be held along the bus routes? What are the riders' ages and disabilities? Do residents from group homes and supported living settings have transportation available to them or are they required to use public transportation? Are they capable of using public transportation? What are the liability and insurance parameters? What cooperative resources are available? What regulations apply? Traditionally, persons with disabilities have been transported by public carriers to places of employment and to procure health and medical needs during nonpeak transport hours, 10 a.m. and 3 p.m., with limited options existing after closure of the workday.

Communication among all employees within an agency and between the agency and its publics is essential to ensure uninterrupted delivery of integrative leisure services. Each staff member and concerned person (parent, advocate, participant) must communicate their expectations and philosophies. Unnecessary fear, anxiety, misunderstandings, and inappropriate participant program placements result from a lack of information or misinterpretation of existing communiques.

The therapeutic recreator must be aware of the agency's avenue for internal and external information sharing and the procedures to access each. Does the agency have a media and graphics department or does a contract exist with a private firm to disseminate information on agency programs and services? Are there tools available internally to make known therapeutic offerings, such as an in-house newsletter or bulletin boards? Have contacts with other social service agencies resulted in their newsletters being available to announce therapeutic happenings? As a result of studying the communication network, staff are aware of other agency contacts and procedures to follow when preparing news items to be presented to the public.

Agencies tend to follow a chain of command when information is presented to the public. Usually involved are clearances on content and use of agency logos and acknowledgment of who has the authority to say what. Accompanying agency policies on chain of command are standards on release of information as defined by the Open Records Act (1973), Freedom of Information Act (1958, amended in 1974), and the Family Educational Rights and Privacy Act of 1974. History has tended to support the maintenance of participant confidentiality. Participant release forms prepared by agency staff permit the use of participant information for either educational, research, or promotional purposes when signed by the participant or a family member.

Cooperation results from the need to share resources and participants to eliminate service gaps and duplication and to enhance integrative opportunities. The therapeutic recreator studies past and present arrangements and agreements to ascertain roles and responsibilities expected or anticipated by divisions within the agency and between the agency and its constituencies. What are department policies and procedures for sponsorship, contractual agreements, and joint ventures with various agencies, organizations, and special interest groups? Cooperative actions may be as limited as rental of pool facilities or as extensive as joint development and operation of after-school leisure education programs using park properties. When a therapeutic program is decentralized, staff must rely heavily on other agency employees to make program resources accessible and, when therapeutic staff are limited in number, resources and personnel must be shared. Long-standing unwritten agreements may dictate the use of a certain facility at a certain time by a particular community agency. For instance, UCP (United Cerebral Palsy Association) may always swim on Saturday mornings at the indoor pool operated by the agency or adults from ARC (Association for Retarded Citizens) practice Special Olympic track and field Thursday evenings on the agency field. The therapeutic recreator familiar with these activities develops a long-range master plan to accommodate such vested interests and relationships.

Standards

Federal, state, and local laws and codes either directly or indirectly impact the operating procedures of a park and recreation agency. Federal legislation having direct state and local impact on recreation include the 1968 Architectural Barriers Act, the 1973 Rehabilitation Act with the 1974 Rehabilitation Act Amendment, Education of All Handicapped Children Act, 1975, the Education of the Handicapped Act Amendments of 1983 and 1986, the Education of the Handicapped Act of 1990, and the Americans With Disabilities Act, 1990. Legislation with less direct yet implied ramifications to leisure services include the Youth Camp Safety and Health Act, Civil Service Reform Act, Federal-Aid Highway Act, State and Local Fiscal Assistance Amendments, Developmental Disabilities Assistance Amendments, Developmental Disabilities Assistance and Bill of Rights Act, Omnibus Budget Reconciliation Act (OBRA), and the Urban Mass Transportation Act. Federal laws, such as these, pass through the state to the local governments where they are to be enforced.

In addition to these standards, local operating ordinances affect food service, land use, aquatic operations, emergency routines, and safety. Standards of performance may be found in the board and advisory committee minutes and directives. Professional standards also exist to guide therapeutic programs. Three documents which identify personnel and management standards include: Standards of Practice for Therapeutic Recreation Service (outlines model program and service standards); Personnel Standards of the National Council for Therapeutic Recreation Certification (defines minimum criteria to be certified to practice therapeutic recreation); and Therapeutic Recreation Practice Act (specifies model content for state licensure laws). A therapeutic recreator cognizant of these standards designs into the master plan measures to comply with the criteria.

Accessibility

During the agency analysis, an underlying concern is to determine the awareness, acceptance, and access of the agency's staff and resources to persons with disabilities. This study goes beyond the state and federal regulations governing program and environmental access to the sincere acceptance of responsibility to establish through mutual efforts "leisure in the mainstream" through integrative experiences. Not only must an agency determine which physical adjustments are needed to allow all participants into programs but also staff readiness to include participants with disabilities in their recreative activities (see Appendix B for a model agency accessibility survey). Therapeutic staff also find that persons with disabilities either new to community residence or those remaining in the community and receiving less support from caregivers experience self-barriers to leisure participation. Consequently, "readiness" of the users as well as of the agency must be ascertained (see Exhibit 2-7).

The agency-wide review determines awareness and feasibility to incorporate persons with disabilities. In some instances the investigation may be actual yardstick measure-

Exhibit 2-7

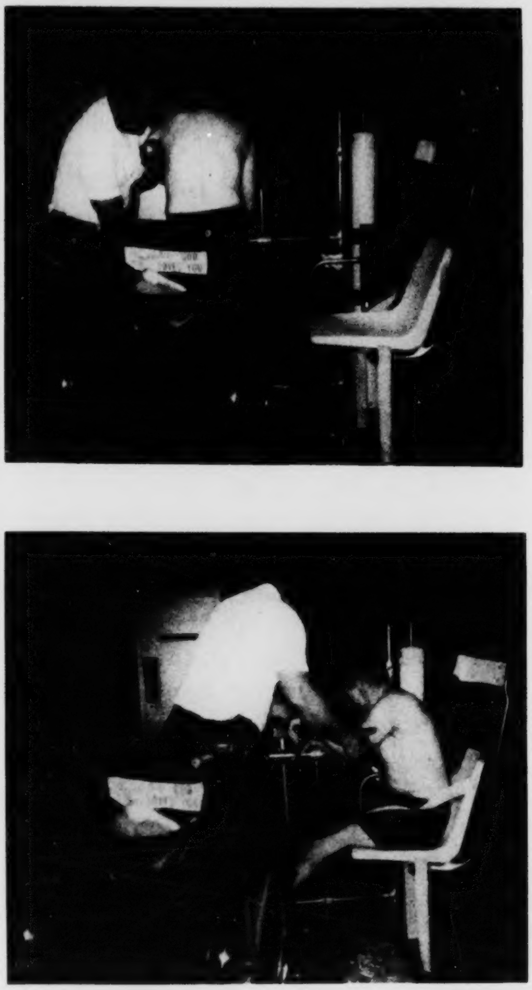
ACTIVITY PREPARATION CONSIDERATIONS/BARRIER AWARENESS

Physical	Architectural
	Ecological
Attitudes, Values, Beliefs	Readiness of society at large
	Readiness of professionals
	Readiness of caregivers
	Readiness of consumers
	Readiness of consumer peers
Resources	Available money, transportation, time, equipment
	Moral support of critical others
	Qualified staff and administrators
	Rules and regulations
	Communication
	Effective service systems
	Adaptations and modifications
	Risk management and quality assurance programs
	Awareness education and in-service training
Consumer	Social interaction skills
	Activity appropriateness
	Level of independence
	Fitness and endurance levels
	Awareness of leisure experiences
	Motivation to participate
	Assertiveness and coping skills
	Protectiveness and safety management skills

ments to establish physical accessibility; in others, the study may have the intent of extending the length of day programs or servicing persons with multiple disabilities or identifying empathy levels of staff toward populations with disabilities. To illustrate, agency buildings may require modification to satisfy ANSI (American National Standards Institute) standards. Or, agency programs that are already integrated may be enhanced by offering early morning and late afternoon programs to accommodate the children of working parents. Summer programs may need to include youth with multiple disabilities because services normally provided by the school are not made available during summer months. And, staff empathy levels influence their abilities to integrate and involve various types of participants in agency programs.

Specific questions to be addressed include: Who is served by the agency's programs and does the population analysis corroborate services rendered? Are available facilities, areas, supplies, and equipment physically, environmentally, and programmatically appropriate to the various populations, such as users of wheelchairs, persons with hearing and visual impairments, persons with mental and emotional disabilities? Do staff accept all persons or are persons with "special needs" given "token" access? What barriers are presented by tradition, fiscal limitations, transportation, and operating standards and ordinances and are these barriers "real" or "perceived?"

Answers are found through observation, personal contact, study of building specifications and supply inventories, discussion with users and staff, and consultation with colleagues and advocates. The role of the therapeutic staff may be in dispelling concerns and attitudes of administrators and staff regarding their perceived inadequacies and ineptness to include participants with disabilities.



Two approaches to making a nonaccessible pool usable by participants.

BEST COPY AVAILABLE

SECTION E: COMMUNITY ANALYSIS

Community involvement in the master planning process is essential to ensure identification of residents' needs while gaining their commitment to the plan's intents. Information from and about the community is necessary to determine the level of community awareness and understanding about therapeutic recreation. The degree of programmatic, attitudinal, and physical accessibility of a community's resources and services must be ascertained. Programming with community residents who are disabled is more successful and cost effective when cooperative planning and sharing of available supportive resources, such as funding, transportation, and volunteers, are considered during initial program development.

Information on the community is uncovered through visits to and collection of brochures from such places as the courthouse, library, schools, churches, social service agencies, media centers, government organizations, transportation services, volunteer organizations, colleges and universities, and agencies offering leisure programs, services, and resources. Reading of community directories, newspapers, ordinances, legislative and council reports, laws and directives, bulletin boards, professional literature, census data, and land-use plans gives the planner a comprehensive view of the community's past, present, and future direction. Staff should attend the regular and special meetings of clubs, organizations, neighborhood groups, and special interest groups in order to collect community information which will be used to develop the agency master plan.

A community survey is similar in content and information gathering procedures to that done within the sponsoring agency. The analysis is broader in scope and is intended to determine the quality, quantity, availability, location, fiscal base, accessibility, condition, scope, and nature of existing and potential leisure services and resources. Resulting from this analysis is the identification of those resources and services external to the agency but which influence the delivery of therapeutic recreation services by the agency.

Programs: Demand and Supply

A visit with those agencies offering leisure services or the collection of information from these agencies by interview or written response determines existing and potential opportunities and may serve to uncover previously unknown resources. Contact with these agencies and organizations also serves to open communication avenues essential to co-planning and integrative programming. Listings of community agencies offering leisure programs are found in community directories, the yellow pages, state professional organization directories, and through community-wide networks of therapeutic recreators.

Collected information organized into a catalog or card file enables the therapeutic recreator to determine service gaps or needs and the status of therapeutic recreation in the community. Storage and retrieval of information on a computer enables potentially massive amounts of data to be readily available to the user.

A community leisure data base or profile might include:

- Program or activity name, purpose, and description
- Participant characteristics
- Season, session, or duration of activities with a time schedule
- Costs or fees, such as membership, registration, late, or withdrawal; special rates, instructors, seasonal changes; and total operating costs
- Transportation available, type, costs, hours, accessibility, and user criteria
- Accessibility of programs, facilities, and areas according to American National
- Standards Institute (ANSI) and Section 504 of the 1973 Vocational Rehabilitation Act Amendment
- Public relations departments--addresses and phone numbers

A document of this nature becomes a supplement to existing community resource directories and facilitates agency and participant access to information and services. Community awareness and acceptance of the leisure service needs of persons with disabilities is also enhanced by the existence of such a public relations tool.

Fiscal Matters

Each community exists for some reason whether it be agriculture, industry, tourism, or commerce. By assessing the economics of a community the therapeutic recreator identifies community growth trends and subsequent leisure needs, the funding base and resources, and financial limits or expectations on the cost of various leisure services. Financial support for leisure services comes from such community resources as taxes, Community Chest or United Way monies, fees and charges, bond and grant monies, and contributions or donations. In turn, accountability measures require the therapeutic recreator to report individual program costs, costs per participant, and administrative costs to their boards and community supporters (see Exhibit 2-8).

Exhibit 2-8

COMMUNITY ECONOMY

To obtain rough indices of potential funding base, growth trends, and resources, the leader may develop charts summarizing significant economic resources. Maintaining updated lists allows quick reference to potential contributors and the frequency of their donations. Such a resource also identifies "hometown" products which one is encouraged to use in programming.

Name of Business or Industry	No. of Employees	Growth Characteristics	Community Involvement	Products or Services
Ex. Make-It, Inc.	75 plus 10 summer youth positions	2-3% in GNP year	Sponsorships and product donations	Paper goods

A community, like an agency, establishes service priorities. A key function of the therapeutic recreator is to remain abreast of how services are funded and prioritized and to share with appropriate advocacy groups the needs unique to budgeting therapeutic recreation services, such as the justification for maintaining raised temperatures in heated indoor pools, lighted walkways, and curb cuts; or the funding necessary to support longer-day programs and summer day camps. The therapeutic recreator must also maintain a record of past and projected expenditures with data available to make comparisons with other similar community agency programs.

Study of the community financial base should reveal sources of philanthropic monies and agencies or organizations whose preference is to contribute proceeds from sponsored events, such as 10Ks or athletic tournaments, to therapeutic recreation programs. A therapeutic recreator knowledgeable of the agency's funding policies is better able to represent the agency in cooperative programming ventures and special events, such as wheelchair basketball tournaments, or in ongoing functions, such as after-school programs operating in community schools and churches. Careful assessment is also necessary to prevent over-solicitation of particular individuals or groups.

Through review of past program documents, agency directives, and governing policies, the posture on alternative ways to financially support programs is ascertained. Traditionally, fees and charges have been one option receiving less than enthusiastic support. A recent trend influencing programs is to use fees and charges coupled with general revenues to finance programs. A survey of the community enables the therapeutic recreator to better establish "accepted" funding policies, such as sliding scales, differential resident and nonresident fees, scholarships, membership fees, payment schedules, and refund criteria. Statistical comparisons with other community social service agencies offering similar services reveal accepted sources of income in therapeutic recreation.

Standards, Trends, and Tradition

Public service agencies must adhere to ordinances, codes, and laws governing the operation of facilities and programs. These standards set criteria on emergency and safety procedures, aquatic and food services, personnel, transportation, equipment and materials, storage, hours of operation, room capacity, and sanitation. The standards are found in city codes and procedural manuals. A therapeutic recreator aware of such regulations plans activities accordingly: numbers attending are not allowed beyond the posted room capacity; program times have considered curfew hours in the parks; chemicals are stored properly; proper documentation using regulation forms of the pH level in the pool is kept; foods are served in the appropriate containers; and an adequate staff-participant ratio is maintained in the pool.

Trends and tradition are an ongoing consideration in master plan design. The allocation of resources is influenced by these considerations. Recent trends have supported: fitness or wellness programs; fees and charges; private-public cooperative agreements;

community placement of formerly institutionalized individuals; early intervention with high-risk persons; functional rather than categorical definition of services; citizen involvement in decision-making; leisure services to persons who are disabled and elderly; and integrative community-based programs. Tradition brings to a service provider past justifications, vested interests, and particular participant needs that may warrant continuation or immediate program redesign. For example, a specific senior citizen program housed in a recreation center and serving as a health-screening and social service access system may be so "ingrained" that discontinuation of the program would result in a confrontation with citizens. Or, an annual donation in the name of a former participant may enable replacement of much needed adapted aquatic equipment.

Trends tempered by tradition set program parameters. Community-based therapeutic recreation programs now serve persons who traditionally have been serviced in residential centers. The sharing of facilities during after-school hours and in the summer and contracting with private firms to market programs result from the trend to maximize available facilities while having increasingly limited monies. Conducting neighborhood input meetings and community-wide advisory council meetings results from citizen advocacy and a greater concern for monitoring the use of their monies. These exemplify programmatic and service delivery trends reflective of socio-cultural-political system changes.

Personnel Resources

The community is a resource to access volunteers, training experts, resource leaders, and staff. The presence or absence of a college in the area with a therapeutic recreation curriculum either enhances or limits the personnel pool. The size of the community determines the availability of supportive agencies and peer organizations with resource personnel. Where a community-wide volunteer bureau exists, ready access to trained volunteers enhances programming. Through study of available community directories and social service agency listings, identification of a personnel resource pool results.

The community "talent pool" should be searched after the availability of agency personnel has been thoroughly assessed. Departmental policies may determine the use and role of volunteers, part-time or seasonal staff, and program experts. Program offerings and budget allocations may also set parameters for staff to be recruited from the community. Personnel resources include agencies or associations that serve or advocate for populations with disabilities, special education classes or schools, junior and senior colleges, service clubs, volunteer agencies, parent groups, churches, group homes, and youth-serving agencies. Maintaining a file of people resources quickly permits the therapeutic recreator to locate needed volunteers or substitute staff.

Geographic and Sociological Features

Geographic influences, such as temperature ranges and precipitation types and amounts, impact participant energy and interest. Natural resources, such as water and unique topographic features, enhance programming by enabling unique participant options. Length of weather seasons and temperature variations impact on the length of programs and use of community resources by increasing or decreasing outdoor recreation opportunities. Access to community physical resources, such as horseback riding arenas, stadiums, pools, and multipurpose outdoor recreation complexes, is also influenced by climactic conditions as evidenced by the opening and closing dates of the neighborhood pool and golf courses. For sources of information see Exhibit 2-9.

Exhibit 2-9

RESOURCES ON GEOGRAPHIC AND SOCIOLOGICAL FACTORS

The type of information the leader will find helpful is found on maps and in reports from a variety of sources. The library is the first place to commence the search. The kinds of information available and additional places to locate resources include:

INFORMATION

Soil maps
Geological maps
Topographic maps
Aerial photos
Land use maps
Legal and zone maps
Flood plain maps
Water use maps
Fish and wildlife maps
Transportation maps
Utility maps
Vegetation maps
Climactic data
Tax assessments and surveys
Demographics
Economic forecasts
Service needs, e.g.,
  referral, protection,
  transportation
Service providers
Issues and trends
Community composition
  or make-up

RESOURCES

Department of Agriculture, Interior, Forest Service
Corps of Engineers
Local airports, weather stations, utility companies
State and county planning authorities
Departments of Health and Human Services
Colleges and universities
Planning commissions
Transit and public works departments
U.S. Bureau of the Census
Economic Development Councils
Residential and industrial developers
Land Management Bureau
Extension or 4-H service
Bureau of Vital Statistics, Chamber of Commerce

Availability of natural areas such as lakes influences program development

Study of socio-economic-cultural features of a community uncovers the public's attitude and knowledge about wellness, integration, and the value placed on therapeutic recreation. A community lifestyle, cultural heritage, and religious mores and customs affect the service expectations of participants, professionals, and significant others. To illustrate, in parts of the United States, Wednesday night is reserved for church related functions; or local and national holidays are celebrated with varying degrees of significance. Single-parent families with children who are disabled, career families, and the loss of the extended family have resulted in social services, such as latchkey programs, being demanded of recreation agencies (Campbell, 1988).

Political, Legal, and Legislative Issues

During the planning process political issues inherent in the community must be identified and addressed. Influential persons representing various special interests must be identified. Their support may be gained by either asking them to be on the advisory committee or spending staff time in their office or neighborhood listening to their concerns about a special group of participants. Funding and volunteer priorities of merchants, the United Way or Community Chest, and various service and philanthropic organizations must be identified so staff assignments are properly made to monitor these groups. Advisory committee member profiles, elected officials' backgrounds, and administrator priorities are reviewed to enable staff to better adjust to their particular concerns.

Understanding of legal directives or ordinances assures the design of risk management plans that account for potential liability issues. Rules governing the use of public transportation or cooperative use of available transportation are reviewed so staff are capable of advising participants of their rights. Local interpretation of federal laws, such as Public Law 94-142 (Education of the Handicapped Act, P.L. 101-476, 1990) and their amendments, is studied to determine if therapeutic recreation is included in special education services as a related service.

The activities of state and federal legislative bodies influence personnel roles and responsibilities and participants' access to services and programs. Staff must be aware of the procedures to follow in order to monitor legislation affecting their programs. Staff also must be aware of what they can say and do with regard to local decision-making bodies. Court actions and decisions influencing participant rights are reported through the media and by such advocacy groups as the Association for Retarded Citizens. Staff have an ethical obligation to stay abreast of such issues as institutionalization, sterilization, employment, and educational rights of persons with disabilities.

Accessibility

During this phase, the therapeutic recreator must ascertain the status of community facilities, programs, personnel, and support systems with regard to accessibility. Barriers to leisure participation extend beyond architectural design; other barriers include the attitudes of staff and caregivers, personal limitations of participants, and lack of or misinformation about programs and services.

ANSI standards serve as guides to gather data about community areas and facilities. Studies may be undertaken by the therapeutic recreator for the purpose of developing a community-wide accessibility guide usable with transition planning. Staff may also use such documents to advise caregivers about accessible leisure resources, such as movie theaters, restaurants, and malls. Community therapeutic recreators who share their studies with clinical therapeutic recreators encourage the transition process and community integration (see Exhibit 2-10).

Readiness surveys, interviews, and observations are used to determine the attitudes and acceptance by staff, administrators, caregivers, and members of the community at large

Exhibit 2-10

COMMUNITY CENTER ACCESSIBILITY STUDY

(Compiled by the Division of Therapeutic Recreation)

KEY:

•	Accessible
o	Accessible with minor barriers or not consistently accessible throughout facility
NA	Not applicable to facility
UC	Under construction
X	Not accessible for wheelchair users

NOTE: Patrons should inquire at each center about precautions and procedures for fire, tornado, etc.

(Exhibit 2-10: Community Center Accessibility Study--Continued)

COMMUNITY CENTERS	ENTRY & EXIT				PARKING				FACILITY			RESTROOMS		
	Main Entrance	Basement Entrance	3rd Floor Entrance	Accessible to all floors from within	Safe, wide parking	Spaces close to building	Reserved spaces for Handicapped Persons	Level Walks with No Curbs from Parking Lot or Street	Doorways (opening widths 32" or more)	Water Fountains	Handrails on Stairways (extending 18" beyond top and bottom steps)	Public Telephones	Clear Entrance for Wheelchairs	Grab Bars
1. BUSH	●	○	X	X	●	●	X	○	●	X	○	X	○	●
2. CLIFTON	●	○	UA	X	NA	NA	X		●	X	○	●	○	●
3. DUNHAM (BUILDING 2)	●	NA	X	X	●	●	●	●	○	X	NA	X	○	○
4. HARWELL	●	NA	NA	NA	●	●	X	●	●	X	NA	NA	○	●

(Exhibit 2-10: Community Center Accessibility Study--Continued)

DESCRIPTION OF MINOR BARRIERS IN THE COMMUNITY CENTERS

1. BUSH

    A. Basement (Gymnasium) Entrance: Since there is no handle on the outside door, an individual would have to call ahead to have community center staff available to open door.
    B. Handrails: There are handrails on all stairways, but they do not extend 18" beyond the top and bottom steps on a consistent basis.
    C. Restrooms: The locker room restrooms off the gymnasium are generally accessible. Clear entrance for doorways should be 32" and is only 30".

2. CLIFTON

    A. Basement: Cannot reach upper level from the basement.
    B. Handrails: Do not extend 18".
    C. Clear Entrance: Required clearance is 32", actual is 31".

3. DUNHAM (BUILDING 2)

    A. Parking Lot: Parking lot is gravel and the roadway to complex is not level. Special permission may be required to park in front of the buildings.
    B. Clear Entrance: Required clearance is 32", actual is 30".
    C. Women's Grab Bars: Required length is 33", actual is 31".

4. HARTWELL

    A. Clear Entrance: Required clearance is 32", actual is 31".

for various populations. Communities may be willing to support integrated programs with learning disabled yet not with those labeled emotionally disturbed. To accommodate all population needs, combinations of both integrated and segregated programs may co-exist. Data gathered during accessibility surveys identify the extent of the need for additional education and information.

Advocacy

Advocacy and awareness are ongoing issues, and educating the community about the intent of therapeutic recreation is an ongoing process. A determination must be made about the level of community, participant, and significant others' awareness and acceptance of the need for therapeutic recreation services. The therapeutic recreator reviews agency marketing materials, news stories, social service agency newsletters, and documentaries to establish the level of understanding regarding therapeutic recreation. A therapeutic recreator communicates the therapeutic intent of recreation through program demonstrations and parent review days, by educating news reporters to participant abilities and achievements, by maintaining documentation on program results for advisory committee reports, and by providing training to network colleagues.

Transportation

Assessment of transportation networks determines the availability of carriers, routes, costs, hours of operation, and physical accessibility. Results of this assessment influence time, location, and frequency of participants' use of community resources. One product of this assessment is a map showing carrier routes, service times, fees, traffic patterns, and flow levels. Therapeutic recreators take these factors into consideration as they develop participant schedules. For instance, programs are offered in time slots that do not conflict with heavy work or school related traffic flow. Likewise, programs are scheduled in time periods when public transportation loads can accommodate special users. Therapeutic recreators may determine that transportation is also available by subcontracting with schools, churches, or peer agencies. As a result of this assessment, staff may determine that there is an ongoing need to educate the community to the transportation needs of users with disabilities, or that participants must be trained to use available transportation resources to access programs and services.

Networking

The establishment of a good working relationship with social service agencies encourages the community's awareness of therapeutic recreation and support of integrated programs. The agency offering therapeutic recreation services needs to assume an advocacy role. Through cooperative visitations, observations, sharing of literature, workshops, and training programs, staff identify community resources and needs (see Exhibit 2-11). These contacts enable a community-wide collection of information on leisure services which are available to users. Analysis of these data, compilation into a directory, and distribution of the directory provide a means to share information on existing and potential resources in order to encourage participant transition and integration among services (see Exhibit 2-12 and Appendix C).

Networking may extend beyond the local community. Through professional contacts and conventions, therapeutic recreators access resources nationwide. The sharing of information and materials adds new ideas, stimulates staff, justifies expenditures, establishes need, confirms decisions, and builds resource files.

Agencies rely on personal and public vehicles to transport to, from, and/or during programs.

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Exhibit 2-11
COMMUNITY NETWORKING MODEL

A networking model is proposed for use by therapeutic recreators as they consider their roles and responsibilities among service providers. Each phase defines one task essential to assurance that all persons will access those services fundamental to integrative programs.

Phase I—Information Gathering. Identification of all potential service providers, populations, supportive personnel and resources, environmental features, and community readiness with regard to all persons. Of particular concern are such real or perceived barriers as transportation, accessibility, and awareness. The parameters in which a network operates is established with this investigation. This activity is ongoing as the system is fluid and interactive in its response to participant needs.

Phase II—Identify Network Service Providers. The data are studied to select representatives from all sectors of the community: community recreation, parents and caregivers, consumers, advocacy groups, school or day placement, medical and allied health personnel, public and private social service agencies, and professional and educational resources. This process should identify other agencies serving the same populations but with different services and other agencies providing the same service to different populations.

Phase III—Form Advisory Team. Persons representative of the network are organized to give direction to cooperation and coordination of services.

Phase IV—Needs Assessment. A status report of existing services is prepared and skills needed by participants in integrative community programs are established. Minimal competency levels are suggested in: mobility and fitness; decision-making; transfer and skill generalization; reality orientation; impulse control; self-defense; safety and discrimination; money and time management; travel skills; comprehension and compliance with verbal and written directions; leisure motivation and skills; self-direction in structured situations; communication; adaptation; ADL (activities of daily living) skills; social interaction skills; planning; and balance.

Phase V—Establish Program Structures and Content. A common philosophy with mutually achievable objectives is delineated. Who will provide what services to whom is defined.

Phase VI—Design Management Plan. A written protocol presents policies and procedures. Fiscal and personnel strategies are adopted and an evaluation plan is formulated.

Phase VII—Implement Training Programs. Ongoing inservice programs disseminate information with consumers, caregivers, advocates, and administrators.

Phase VIII—Market Services. To continue to create avenues to access ongoing communication is necessary to educate the community at large to the network.

Phase IX—Implement Services. As participants are followed through the system formative evaluation assures effectiveness of the services and processes to participant needs.

Phase X—Evaluation. The reality of networking is documented with validation that predetermined objectives are updated with participant achievement.

Phase XI—Follow-up. Formalized processes assure integrative experiences. Examples of such tools include: individual contracts; volunteer buddies; computerized call-in systems; advocacy check-in; companion programs; and scheduled meetings.

Exhibit 2-12
LEISURE NETWORK DIRECTORY

A computerized directory serves as a resource to the participants, caregivers, and professional staff throughout the community. This directory also justifies needed programs and advertises available activities to audiences who might be considering a move to the community.

Activity or program	Agency address contact	Participants served	Seasons or sessions	Costs	Notes
Ex. Bowling	Wind-up 6th Ave. 214-BOWL Arnold	Persons aged 6 and up	Year-round	$2.00 per visit	Scholarships available; Accessibility OK
Ex. Crafts	Culture Center Paint Dr. 214-ARTS Crafty	Youth	Sept-Dec and Feb-May classes	Material costs plus $5.00 per class	All art forms used; Volunteers must assist

SUMMARY

This portion of the publication is organized to reflect the need first to determine "who" the potential participants might be, "what" is currently available within the agency itself, and lastly, "how" the community is able to assist the agency to offer services to the identified populations. In this phase of program development several tasks may occur simultaneously. Completion of one step is neither a prerequisite to the next nor dependent upon the next; yet, this entire phase of assessment pre-empts the next stage of program development and influences the implementation and delivery of programs.

Collection of information during the assessment phase occurs using a variety of methods and techniques, the combination of which is time-consuming yet essential to program development. The selected procedures must be suited to the intent of the surveyor, the data to be collected, and the use expected of the information.

During this process the therapeutic recreator gains the advisory committee's support while using their expertise to guide in data collection and to make decisions about program scope and structure. Analysis of the population information collected determines key segments in need of services, their ability levels, and their particular needs, interests, and skills. Analysis of data collected on the agency reveals the resources, assets, and potential limitations of the agency to offer therapeutic recreation. Likewise, analysis of the data collected about the community as a whole reveals the involvement and commitment of the community to serving persons with disabilities. The scope of data collected during agency and community assessments is broader than that collected during the population analysis as noted by reference to the various categories found under agency and community assessments. Thorough collection and analysis of data is critical during this step in program design. The therapeutic recreator is actually gaining support for programs from significant community members while also gathering information necessary to the decisions made in all future planning steps.

KEY TERMS

Accessibility. A person's access to programs and services without encountering physical, attitudinal, or self-imposed barriers or limitations.

ADL (activities of daily living). Activities completed to meet basic needs, such as eating, dressing, feeding, bathing, and grooming.

Advocacy. The process of demonstrating support for, with, and on behalf of people with disabilities.

ANSI. A guide prepared by the American National Standards Institute, Inc. which is used to design barrier-free environments.

ARC (Association for Retarded Citizens). National advocacy group providing services, including leisure, to persons with mental retardation.

Centralized. Provision of leisure services from one site or at one location in the community or district.

Community. A group of people living within a specified geographic area. A generic term used to describe the public, non-profit, private, and government agencies, services, and programs located in one area.

Community master plan. The written document that outlines need, supply, demand, resources, and the leisure service action plan for present and future community services.

Decentralized. Provision of leisure services from centers located at various sites throughout the community or district.

Formative. Evaluation conducted during a program (process evaluation).

Helping relationship. A supportive relationship during which the leader uses specific interaction and intervention skills during therapeutic experiences to facilitate participant growth and development toward holistic well-being.

IEP (Individual Education Plan). A written statement outlining special education and related services which are to be provided to the handicapped child. IEPs are mandated by Public Law 94-142 (Education of All Handicapped Children Act of 1975).

Integrated programs. Recreation simultaneously offered to persons with and without disabilities.

Naturalistic observation. Assessment and evaluation technique in which participants are observed during typical therapeutic activities.

NTRS (National Therapeutic Recreation Society). A branch of the National Recreation and Park Association. NTRS is an organization that represents the interests of professionals employed in therapeutic settings.

Public Law 94-142 (Education of All Handicapped Children Act of 1975). A federal law that requires every handicapped child to receive a free, appropriate, public education. One of the sections deals with related services, including recreation which is defined as assessment of leisure function, therapeutic recreation, recreation programs in schools and communities, and leisure education.

Risk management plan. A document outlining management strategies designed to assure that precautions are taken to control potential safety concerns.

Section 504 of the 1973 Vocational Rehabilitation Act Amendment (Public Law 93-112). A civil rights statute which states that programs and activities receiving federal assistance must be made available to all persons with disabilities.

Segregated programs. Recreation offered exclusively for either persons with or without disabilities, that is, one program does not accommodate both simultaneously.

Summative. Evaluation conducted at the end of a program (product evaluation).

Therapeutic recreation. The application of selected experiences through a helping relationship to facilitate participant growth and development toward purposeful leisure and holistic well-being.

Therapeutic recreation process. A generic, systematic, decision-making approach consisting of four sequential and interrelated phases used to prepare, deliver, and revise programs and services to achieve purposeful, participant-centered outcomes. The four phases are assessment, planning, implementation, and evaluation.

Transitional programs. Recreation programs intended to help participants acquire or develop skills and personal resources needed to adjust to changes occurring during their movement from one service delivery setting to another.

UCP (United Cerebral Palsy Association). A national advocacy group providing services, including leisure, to persons with cerebral palsy.

TRAINING EXPERIENCES AND STUDY QUESTIONS

1. Attend two meetings. One should be an advisory committee and the other a decision-making board, such as a government meeting or staff meeting. Compare the structure and operation of the two. Who seems to be in control of each meeting? What types of decisions are made by each type of committee or board?
2. What resources or techniques can be used to identify action leaders, decision makers, and communicators in a community?
3. Contrast and compare advantages and disadvantages of written, oral, and observation assessment techniques. What populations or circumstances lend themselves to each assessment technique?
4. Conduct either an agency or community analysis by using the material identified in each subsection as a guide. Where and how is information found? What are useful resources and contacts?
5. Outline the primary influences on the assessment process. Explain why there are a limited number of assessment tools available in therapeutic recreation. If a therapeutic recreator chooses to design an instrument, what guides can be followed to assist the designer?
6. Study the census data on a community, region, or state. What information that is found is useful in program development? Describe its application or implication on services delivered.
7. Interview a planner and/or engineer to determine the process used to design a community master plan. Visit the library or community planning agency to review samples of community master plans.
8. Consult with persons in "systems design" or computers to identify the application made of "systems programming." Study the materials by Duncan and Peterson noted in the reference list to identify the application of systems planning to camping and therapeutic recreation.
9. Review information available from government offices and committees, such as the President's Commission on Employment of People with Disabilities, to ascertain what it costs to care for persons with disabilities within the community compared to caring for them in an institution.

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PART II

PERSONS WITH DISABILITIES

INTRODUCTION

This portion of the publication summarizes general demographic information, functioning characteristics, and needs of community participants. Each section contains population descriptions, functioning characteristics, and implications for therapeutic recreation. Each discussion presents the ability ranges characteristic of participants in that particular category. The intent is not to discount individual needs but rather to present a large amount of material according to potential service levels.

Community agencies have assumed responsibility to service participants having a broader array of functioning abilities than when these programs were first initiated in the 1950s and 1960s. Formerly institutionalized participants now living in group homes and supportive living settings seek leisure resources. Staff from hospitals complying with more stringent financial regulations are transitioning newly traumatically injured persons into community programs at a quickened pace. Prevalence of the "wellness attitude" is encouraging participation by post stroke and cardiac patients. Substance abusers, persons with criminal records, behavior disordered youth, and aging persons recreate in community settings.

Youth with mental disabilities remain the most commonly served participants followed by persons with physical disabilities, excluding visual and hearing limitations, and youth with emotional, educational, and learning disorders. Specialized programs

Community agencies are now servicing participants with a broad array of functioning abilities, and today's staff need information about a wide variety of populations seeking recreation.

serve those with severe and multiple disabilities, such as persons with autism. Evening, weekend, and special events programming accommodate persons with mild to moderate limitations who are in the work force. Adults with specialized needs attend day therapeutic programs. And youth and adults with appropriate social and leisure skills participate in integrated experiences in a variety of community settings. Information covered in this portion of the text is intended to familiarize readers with the scope and nature of participants who seek recreation in the community.

SECTION A: MENTAL DISABILITIES

Population Descriptors

Mental retardation is a term applied to children whose learning abilities and general adaptations to society are below average and to adults who do not display age-appropriate behavior (Carter, Van Andel, & Robb, 1985). The term refers to significant subaverage general intellectual functioning existing with deficits in adaptive behavior that are manifested during the developmental years. Poor intellectual performance refers to performance two or more standard deviations below average on a standardized intelligence test. Deficits in adaptive behavior encompass maturation, learning, and social adjustment, and are exemplified by age-appropriate independence and assumption of social responsibilities. To be diagnosed as mentally retarded a person must display deficits in both intellectual functioning and adaptive behavior prior to age 22. This definition permits the label "mental retardation" to be applied during one period in a person's life and not at another. To illustrate, the child who displays deficits in self-help, communication, socialization, or sensorimotor skills may be considered to be mentally retarded. But as an adult if employment is achieved and socially appropriate skills are in evidence, the label may not be applicable.

Mental retardation varies with age, sex, geographic location, socioeconomic levels, and cultural levels. In the average community, of every 1,000 school-age children, 25 are mildly retarded, four are moderately retarded, and one is severely or profoundly retarded (Sherrill, 1986). More males than females are diagnosed as mentally retarded.

The majority of the children wearing the label "mentally retarded" live in the community as do the adults who wear the same label. Medical advancements have increased the life expectancy of those with severe and profound retardation. Persons with mild retardation tend to live normal life spans.

Functioning Characteristics

The person who is mildly mentally retarded is much more like a "normal" person than different. The majority, or approximately 89 percent, of those who are mentally retarded are mildly impaired. Many are known as "six-hour retarded children" since their deficits only appear during the academic day of their school years. Their mental development is one-half to three-fourths that of the normal level with most, 80 percent, marrying and raising families (Sherrill, 1986). Blue collar employment as custodians, maintenance workers, restaurant employees, and medical orderlies is common.

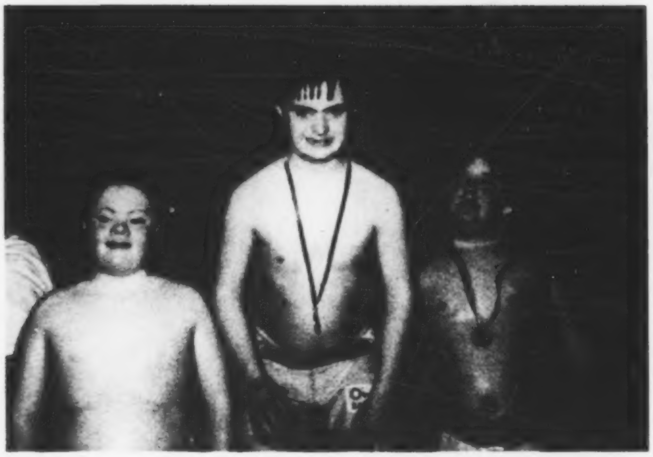
Persons who are mildly mentally retarded tend to have lower levels of physical fitness, are less accurate in such motor areas as balance, coordination, and throwing, exhibit verbal deficiencies, and require training to manage stress and appropriately express their emotions. Frustration and lowered tolerance levels result from "almost but not quite" experiences. Their borderline skills tend to place them at the edge of success.

Persons who are moderately impaired are identified early in life because they display clinical or physical signs, such as delayed walking or talking. Of those labeled moderately mentally retarded, 30 to 40 percent have Down's syndrome. Mental development is equivalent to that of early elementary age children yet social maturity and physical prowess reach that acquired during the teen years. These persons tend to be overweight, have noted deficits in verbal and expressive communication, lack maturity in social-emotional behavior, and experience difficulty with abstraction and comprehending lengthy instructions or requests. They display deficits in higher level motor skills, such as catching with accuracy, maintaining speed over time, repeating motor skill patterns in such activities as basketball, and in strength and flexibility.

The smallest percentage of persons with mental retardation are the severely and profoundly retarded. These persons are identified early in life because of their multiple deficits and secondary disabilities, such as cerebral palsy, epilepsy, and autism. Parent advocacy resulting in legal mandates has enabled persons with severe and multiple disabilities to remain in the community rather than to be placed in institutions soon after birth. Persons in this functioning range lack spontaneous play skills and the ability to attend, to imitate, to relax, to move about freely, to communicate more than their fundamental needs, to express likes and dislikes, and to socially interact. They are capable of learning fundamental safety skills, activities of daily living (ADL), and self-help skills. Retention of primitive reflexes and behaviors causes poor posture, limited environmental awareness, and limited purposeful movement.

Persons with Down's syndrome represent the largest single group of persons with moderate and severe retardation. The presence of specific physical characteristics tends to separate and distinguish this population. The characteristics commonly apparent are upward slanting eyes, a protruding pointed tongue, smaller oral cavity, square flat hands with short fingers, broad short necks with loose skin on the sides and back of the neck, a small nose with low bridge, flat back of skull, sparse, fine, straight hair, and dry mottled skin. Persons with Down's syndrome are shorter than average and appear stocky in build because their arms and legs are short in relation to their trunk. Mild to moderate obesity is not uncommon in late childhood and adulthood.

The adult with Down's syndrome tends to age more rapidly than usual. Social development is more advanced than mental development and, when combined with their memory and ability to mimic, the impression is that they know more than they actually do.



Children with Down's Syndrome participate in swim program

Emotions are less intense and their moods tend to come and go quickly (Carter, Van Andel, & Robb, 1985). Persons with Down's syndrome experience balance deficiencies, have badly pronated flat feet, and tend to walk with a shuffling gait. Some are perceived to be double jointed due to the lax ligaments and apparent looseness of the joints. This condition contributes to atlantoaxial instability. The muscles and ligaments around the joint of the two cervical vertebrae, the atlas and the axis, are lax, allowing the vertebrae to slip out of alignment causing damage to the spinal cord. This condition has caused most service providers to mandate an X-ray of the spinal column prior to program admission.

The lower the level of measured intelligence, the greater the effect of retardation on interpersonal and social relationships. Intellectual deficits limit the ability to discriminate between meaning and sounds and to interpret gestures. The stares and avoidance reaction of the general public to those who appear different are familiar. The more the public is exposed to persons with disabilities, the more comfortable they are in accepting persons with more obvious deviations. The limited adaptive behavior of persons with mental retardation also influences social adjustment. Dependence on caregivers to assist with activities of daily living and self-help skills creates extended parent-sibling relationships, thereby exposing the participant to parental overprotection and reduced opportunities to experience social interaction among peers.

Psychological problems faced by persons with and without disabilities are similar. Persons with mental retardation experience more stress because of their limited ability to identify and cope with those forces influencing emotions. Additionally, continued overprotection and denial and neglect by significant others leads to poorly developed self-concepts. With weakened self-concepts, accurate assessment of self-worth and ability levels is not likely to occur. Consequently, realistic goals are not set. Self-evaluation becomes self-defeating and results in feelings of failure and frustration.

Although persons with mental retardation function physically closer to their chronological age norm than to their intellectual norm, they still experience varying degrees of physical deficits. Perceptual motor deficits are prominent as evidenced in poor visual tracking, eye-hand coordination, skipping, jumping, and hopping. Inability to plan movement patterns and to transfer or generalize from one experience to another causes the appearance of routine, arhythmical motor patterns and the inability to control the overflow resulting from rapid voluntary movements. The appearance of tics and continuing to march when the music is stopped exemplify these motor limitations.

Implications for Therapeutic Recreation

Persons with mental retardation experience a limitation in their capacity to recognize and satisfy their psycho-social needs. Participants need to experience a variety of social situations to realize that, with each, different rules and expectations may apply. The group nature of many community-based recreation experiences enables acquisition of social amenities. Participants must be taught the skills needed for individual and small group activities as a disproportionate amount of their time is spent either alone or with members of their immediate family. Nonverbal social cues may not be recognized and words are interpreted literally. Through properly selected and led activities, participants are provided opportunities to role play social expectations and acquire adaptive behavior skills, permitting acceptance as group members.

Unrealistic expectations of self result from overprotection, limited experiences, and the inability to explore or "test." Participants become more aware of their capabilities when the leader sets up self-testing options in the activity experiences. A realistic self-concept results from opportunities to make decisions and choices and to express likes and dislikes.

Parachute activities offer manipulation and exploration in use of body parts

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Recreational cooking is a learning medium for vocational and independent living skills

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Participants need to understand the cause-and-effect relationship between various body parts and their respective movements. These skills are developed during movement exploration and manipulation through obstacles. There may be a need for the leader to moderate hyperactivity, abusive behavior, or socially unacceptable behaviors, such as rocking, biting, or spitting. Motor activities offer opportunities to channel and reduce such actions while gaining skills in coordination, planning, fine motor tasks, visual tracking, staying on task, and improving fitness. Movement experiences serve as a laboratory to improve academic and vocational skills, such as recognition of colors, numbers, money, time, word and sound discrimination, sharing, waiting, following directions, and responding to an authority figure. Leaders must remember to individualize within the group as there is more variability than similarity among participants.

Persons with mental retardation experience limitations in ability to learn that are complicated by language problems. Their vocabulary or capacity to learn does not improve with age; rather, they may become less attentive and more difficult to teach. Problem-solving, judgment, and evaluation skills are noticeably limited as shown when a participant is called upon to select from several alternatives. Creativity, application, and discrimination are lacking in their recreative behaviors. Therefore, they appear to have a limited ability to occupy their own time without structure being imposed by a leader.

SECTION B: PSYCHOLOGICAL DISABILITIES

Population Descriptors

Persons with emotional disabilities have chronic or noticeable problems coping with day to day social mores. Society defines "abnormal" behavior as any behavior that differs from the perceived norm. We live by a set of explicit and implicit norms or rules of conduct that identify acceptable and unacceptable behavior. Those living in sociocultural environments with relatively homogeneous standards generally agree upon the rules governing their lives. In a diverse or pluralistic setting, such as a city compared to a small rural area, variance exists among established norms. As society becomes more pluralistic fewer behavioral differences are described as "abnormal."

Statistics given for the incidence of emotional disabilities, behavior disorders, or mental illnesses vary from 2 to 30 percent of the school age population with 5 to 15 percent of all persons believed at some time in their lives to be emotionally disabled. This variance is due primarily to the lack of consistency in describing what constitutes an emotional disturbance. The medical system used to classify persons with deficits in behavior is the DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, third edition, revised). As with other classification systems, the use of the DSM system permits professionals to access funds and services and serves to create a common language among professionals who interact with these individuals.

Like persons with mental disabilities, there is as much difference as similarity between participants labeled with the DSM system. In the community, there is an increasing number of these persons who are serviced by out-patient mental health centers. The majority of youth with emotional disabilities remain in the community and attend special education classes or specialized private schools. A therapeutic recreator must be familiar with the numbering system and nomenclature of the DSM system to comprehend the reasoning behind the IEPs (individual education plans) of school-age children and to plan for their referral to other community services.

The causes of emotional deficits are attributed to heredity, organic conditions, and functional conditions. Depression is believed to be inherited. Organic causes are present in glandular imbalance, neurological degeneration, such as Alzheimer's disease, brain damage, and stroke. Functional conditions describe internal and external influences on the person, such as real or imagined pressure from peers, and are given as the most common cause of emotional disorders. Persons who are emotionally disturbed as youth are likely to experience behavioral deficits as adults. One in six adults has problems severe enough to warrant professional help. Persons in lower socioeconomic levels are prone to experience social deficits more so than those classified as middle or upper class. Many children with emotional problems are first diagnosed upon entry into school. The common ratio of males to females is given as 4:1 (Sherrill, 1986; French & Jansma, 1982).

Functioning Characteristics

The disorders commonly seen in the community setting fall within one of the following categories: emotional, social, psychotic, childhood, and organic. Common characteristics may prevail, such as behavioral extremes, irrational and unpredictable behaviors, and the hardened or stereotypic personality resulting from a lifetime of socially unacceptable behaviors. Each of the five categories will be reviewed and general functioning characteristics presented.

Emotional Disorders. The common prevailing characteristic is anxiety that is generalized and continues beyond the specific stimulus. Persons are in touch with reality and are able to cope with daily life yet they may complain of backaches, headaches, insomnia, and memory loss when in the presence of perceived stressors, such as their boss or a family member.

Social Disorders. Social disorders include personality disorders and addictive disorders. A personality disorder is described as a long-standing pattern of distorted relationships in perceiving and thinking about the self and the environment. Anti-social and passive-aggressive personalities are two of the more common types. Alcohol, legal drugs, and illegal drugs, when they become physiologically and psychologically addicting, cause addictive disorders. The use of the substance is labeled a disorder when its use results in behavioral changes negatively affecting work, leisure, social functioning, or welfare of self and others.

Psychotic disorders. A distinguishing feature of these disorders is the inability to perceive, process, and respond to reality or environmental situations. Two of the more common forms are affective disorders (depression) and schizophrenia. Depression is commonly treated in community settings and is characterized by loss of interest in usual activities, too much or not enough sleep, weight loss, feelings of worthlessness and guilt, difficulties in thinking, fatigue, and recurrent thoughts of death and suicide. Schizophrenia is the most common diagnostic category and the cause of at least half of the hospitalizations due to mental illness. The person is not able to think coherently, and there is a tendency to withdraw from or distort reality via hallucinations and delusions.

Childhood disorders. As children grow, they experience stress and tension, more so during rapid change periods and when they transition from one developmental period to another, such as those that occur around ages 6-7, 9-10, and 14-15. Children commonly experience disorders in attention, conduct, attachment, self-identity, sleep, eating, elimination, and speech. These disorders are shown in the form of hyper-hypoactivity, abnormal fears, immature social responsiveness, insomnia, obesity, anorexia nervosa, enuresis (bed wetting), stuttering, and tics.

Organic Mental Disorders. These disorders are associated with damage to or aging of the brain. Two of the more common forms found in community therapeutic recreation programs are Alzheimer's disease and stroke. Persons with brain trauma and brain poisoning are also among the participants. Major symptoms are disorientation and confusion, loss of or impaired memory, inability to learn or perform intellectual functions, impaired judgment, and limited control of affect or feelings.

The more severe the emotional disorder, the less physically fit the participant tends to be. The emotional deficits, such as non-attending and withdrawal, will in time limit development of cognitive and motor skills. Persons with emotional deficits tend to physically act out rather than verbalize their felt needs. No predictable skill level or consistent display of energy can be anticipated. Misperception of authority figures may cause distorted reaction to the leader. Apparent lack of concern for safety and following rules is sometimes evident. Lack of motivation and disinterest in an activity may be attributed to either the disability itself or the medication prescribed to treat the illness. A preoccupation with thoughts also causes participants to be nonattentive and out-of-touch with an activity.

It is common to have a problem relating to other people. With children this is seen when hitting and kicking are used to gain attention or defy authority. With adults the perception of every activity as being a "must win" situation or the limited ability to function as a team member are examples of immature socioemotional development. Having a poor self-concept is typical. Change is met with resistance, fear, or overanxiousness. Attention getting behaviors may disrupt a class or result in harm to another participant.

Implications for Therapeutic Recreation

Impaired emotions affect all areas of behavior, with social inadequacies being especially noticeable. The control of impulses through accepted physical outlets, such as volleyball, and satisfaction derived from task completion and achievement of realistic goals foster independent social functioning. Physical activity also offers a way to communicate and gain success, both of which are social needs of participants. The therapeutic recreation setting is a controlled environment and, as such, participants, without fear of recourse, practice or role play social expectations, such as dining out or using the facilities of a private health club. The art of winning or losing is practiced as is adjusting to authority figures and others on the team.

Participants require structure, boundaries, defined goals, objective feedback about performance, and encouragement to become self-motivated. These needs are addressed by establishing game rules and by selecting self-reinforcing activities, activities with graduated achievement levels, and self-testing activities, such as challenge and adventure programs. The participant must learn to relax, to live in the here-and-now, to be spontaneous, and to laugh or experience happiness through fun activities. Participants tend to become dependent and exhibit limited decision-making and problem-solving skills. Experiences requiring verbal expression and selecting alternatives foster development of assertive behaviors and the ability to choose or decide "what I want."

Therapeutic recreation offers opportunities to develop physical well-being through cardiovascular and endurance activities, such as swimming, walking, and aerobics. If persons are physically stronger, their self-image is enhanced.

Participants' range of emotional disorders is diverse. Persons labeled "mentally retarded" display immature emotional behavior. Students from public school behavior disorder classes appear as either withdrawn or the "bully." Adults who have experienced extensive time periods of inpatient or outpatient treatment have stereotypic "institutional" behaviors.

SECTION C: SUBSTANCE ABUSE

Population Descriptors

Substance dependence and abuse result when either natural or synthetic chemical substances are used for nonmedical reasons and affect the body's psychological and physical functioning. Substance dependence and abuse are defined by a list of behaviors presented in the Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-111-R). Dependence upon a substance is applied when at least three of the nine listed symptoms have persisted for a month or more or repeatedly over longer time periods. When a substance is abused the same criteria apply. Additionally, the substance is continually used despite an awareness that social, occupational and physically hazardous

Pick-up ball in community recreation center can provide satisfying experiences for mentally and emotionally impaired youth

situations exist. Use of nicotine or caffeine illustrates the difference between dependence and abuse. Both create a physical and psychological dependence yet neither are substances causing "abuse" like alcohol or cocaine.

There are several types of substances that are abused or upon which persons depend. Males are more often involved than are females, and children of abusers or persons with specific personality disorders are higher risks. Alcohol is abused by persons in their 20s to 40s while other chemicals are abused by persons in their teens and early 20s.

Behaviors indicative of substance dependence and abuse include:

1. The substance is consumed in larger quantities over longer time periods than originally intended.
2. The substance is knowingly used in excess, yet control or reduction in use does not occur.
3. Excessive amounts of time occur in acquisition, use, and recovery from the substance's effects.
4. Symptoms of withdrawal or intoxication occur during personal and professional responsibilities.
5. Social, occupational, and recreational activities decline as a result of substance use.

6. Social, psychological, and physical problems occur with continued use of the substance.
7. With use, tolerance levels decrease causing increases in the amounts consumed to reach desired effects.
8. Withdrawal symptoms develop when substance use levels decrease.
9. Consumption continues to compensate for discomfort of withdrawal symptoms.

Prevalence estimates are higher for alcohol and nicotine than for other substances. Also, alcohol is more commonly consumed in combination with other substances than any other abused substance. It is often mixed with cocaine and narcotics. One out of 10 adults who drink an alcoholic beverage may experience problems with its use at some time in their life; in any six month period, nearly 12 million persons abuse alcohol. Estimated prevalence of chemical abuse is as low as 2 percent to as high as 10 percent (cocaine) of the adult population. A summary of the types of substances which people either depend upon or abuse includes effects on a person's functioning abilities, examples, and street names.

SUBSTANCES

Functioning Effects	Example	Street Name
Stimulant to central nervous system	Amphetamines Dexedrine Benzedrine Methedrine Ritalin	speed, bennies, black beauties
	Cocaine	coke, crack, free base, star dust
	Caffeine tea coffee	
Depressant to central nervous system	Tranquilizers anti-anxiety or minor; Valium, Librium anti-psychotic or major; thorazine, mellaril, haldol	tranks, downers
	Barbiturates amytal nembutal luminal	barbs, goofballs, yellow jackets, purple heats, red devils

	Inhalants	
	solvents	airplane glue, correction fluid, gasoline, nail polish remover
	aerosol spray	freon, hair spray, insecticides
	anesthetics	ether, chloroform
Hallucinogens alter mood, thought, senses	LSD or d-lysergic acid diethylamide	acid, barrels, California sunshine
	Phenylethylamines mescaline designer drugs MDA, PMA, DOM	magic mushroom, love drug, ecstacy, death drug
	Atropinic jimson weed	devil's weed, loco weed
Phencyclidine stimulant, depressant and hallucinogen	PCP	angel dust, peace pill
Cannabis alter mood and perception	Marijuana	grass, pot, weed
	Hashish	hash
Narcotics, opioids lower pain perception	Heroin Morphine Codeine	horse, junk, Harry, H, M, morph, Miss Emma, school boy
Alcohol (ethanol) depressant to central nervous system	Beer, wine, liquor rubbing alcohol	
Nicotine bronchitis, emphysema, heart disease	Tobacco in cigarettes, cigar, pipe, chewing	
OTC (over the counter drugs) physical and psychological dependence	Hypnotics	sleeping pills
	Antihistamines	cold remedies
	Ibuprofen	pain relievers

Functioning Characteristics

Substance use affects each individual differently. In this section, factors affecting individual responses, methods of substance consumption, and effects on the user are summarized. A user's body weight and size affect response to substance use. A larger person experiences less impact from taking the same dose than does a smaller person. A user's absorption, distribution, metabolism, and excretion rates affect response to substance use. Thus, younger children and older adults are more sensitive to substance use. Eating slows the absorption of substances while drinking fluids with substances increases their absorption rate. Body fluid dilutes alcohol and some other substances. Given two people of equal weight, a smaller substance dose will have the same effect on the person with less body fluid. Physical and psychological health affects user responses. To illustrate, poor nutrition, chronic disease, the user's expectations, and the setting in which the substance is used alter sensitivity. With repeated use, tolerance or decreased responsiveness develops, so dose size is increased to produce the same response. Thus a person tolerant, for example, to alcohol or barbiturates experiences less effect from moderate doses than does a nonuser.

Stimulants. Amphetamines, like ritalin, affect the central nervous system, respiratory, and gastrointestinal systems. In low doses, increased breathing, heart rate, and blood pressure and a heightened sense of well-being result. Users become talkative and restless and feel a sense of power and superiority. Complications from either an overdose or abuse include convulsions, coma, heart problems, malnutrition, bizarre behavior, and death. The substances are consumed orally, sniffed, or dissolved and injected into the veins.

Cocaine is also a stimulant, having effects similar to amphetamines. Cocaine maybe sniffed, injected, smoked, or rubbed on mucous membranes and absorbed into the blood stream. Heart rate, respiration, body temperature and blood pressure increase with its use. A euphoric condition is created. Chronic users experience restlessness, anxiety, insomnia, paranoia, weight and appetite loss, depression, hallucinations, hypertension, seizures, and respiratory and cardiac failure.

Caffeine is the most widely used substance found in beverages, medications, and illegal substances. Low doses cause increased metabolism, body temperature, and blood pressure and reduced visual and auditory reaction time. Increased dosages cause nausea, diarrhea, and insomnia. The use of this stimulant has been linked to high blood pressure, coronary artery disease, and cystic breast disease.

Depressants. Tranquilizers are usually consumed in pill or capsule form and are taken to produce a calming effect yet may cause drowsiness, confusion, depression, muscle spasms, and incoordination. Continued use results in impaired judgment, slowed reaction time, and reduced vision. Coma or death may result either from an overdose or as a consequence of mixing with other types of depressants.

Barbiturates are often prescribed for sleep disorders with older adults. As with tranquilizers, small doses reduce anxiety and cause mild euphoria. Larger doses cause intoxication, intense unpredictable emotions, loss of coordination, unconsciousness, and respiratory failure when mixed with other depressants or alcohol.

Signs of abusing inhalants include chemical odor on the breath or clothing, mouth or nose sores, drowsiness, altered time and distance perception, and the presence of rags and empty cans or tubes. Small amounts of inhalants cause euphoria, nausea, and coughing. Use over extended time periods causes memory loss, fatigue, depression, weight loss, and permanent damage to the lungs, brain, liver, and bone marrow.

Hallucinogens. LSD is one of the most powerful hallucinogens that is consumed orally. Initial use causes increased heart rate, blood pressure, and body temperature, impaired coordination, nausea, and vomiting. Long-term use causes distorted time, space, and vision perception and loss of control over thought and concentration. Users of phenylethylamines experience peacefulness and heightened states of consciousness with larger doses causing convulsions, coma, and death. Atropinic is used medically to suppress tremors and relax smooth muscle spasms while abuse of the substance results in consequences similar to the other hallucinogens.

Phencyclidine (PCP). PCP may be smoked, injected or taken orally. PCP users tend to also use alcohol and cannabis (marijuana). PCP effects are cumulative with mild to severe outcomes. Impaired sensation, concentration, coordination, and attention; increased heart rate and breathing; confusion, depression, agitation, and irrational behavior are possible outcomes. Continued use and high doses cause heart and lung failure, coma, and death.

Cannabis. Marijuana and hashish are either smoked or mixed with foods and may be used in combination with other substances, particularly alcohol and cocaine. Users tend to be younger than with other substances. Initial use results in feelings of well-being, relaxation, and arousal while long-term use causes loss of coordination, confusion, distorted perceptions, reduced responses, and interference with intellectual performance. The risk of lung damage, cancer, and heart problems increases with use.

Narcotics, Opioids. These drugs are medically prescribed to relieve pain, coughing, or diarrhea. Heroin is the most frequently abused narcotic. Legally prescribed drugs and heroin are taken orally, injected, inhaled, or smoked. Abuse of narcotics causes drowsiness, mood swings, mental confusion, and loss of judgment and self-control, with an overdose leading to coma and death due to respiratory depression. These drugs are popular street drugs as they are consistently pure and of predictable strength.

Alcohol. Initial behavioral changes with alcohol consumption occur when the blood alcohol level (BAL) reaches .05 percent or one part alcohol to 2,000 parts blood. At .2 percent BAL motor and emotional control is impaired, and at .3-.4 percent BAL unconsciousness results. Chronic heavy drinking leads to damaged liver, heart, pancreas, brain, and nervous systems, sexual dysfunction, malnutrition, and cancer.

Nicotine. Inhalation of cigarette smoke is the most common form of nicotine dependence. The frequency of reinforcement and the physical dependence support the cigarette "habit." Low nicotine levels cause nausea, dizziness, and increased heart rate, blood pressure and respiration rate, while long-term use leads to cancer, heart disease, emphysema, and osteoporosis.

Over-the-counter drugs (OTC). Hypnotics are sleeping aids which contain antihistamines that cause impaired concentration and motor functioning. Antihistamines found in cold remedies cause confusion, delusions, tremors, restlessness, and impaired coordination and judgment. Ibuprofen, approved for sale in 1984, causes less gastrointestinal and kidney problems than aspirin, yet when taken in overdoses, stimulates the brain and spinal cord resulting in respiratory failure, coma, and death.

Implications for Therapeutic Recreation

The use of substances reduces anxiety, relieves tension, allows escape from "reality," provides a "lift" from depression, and enables the user to relax. These payoffs are similar to those found through therapeutically designed programs. Additionally, through leisure education, skill in leisure alternatives and time options are acquired.

Substance abusers display poor self-images. Attention seeking behaviors are outward signs of rejection, loneliness, and fear of failure. Target games, hobbies, and crafts present opportunities for recognition and reinforcement from others. The opportunity to laugh and experience spontaneous fun occurs during theme parties and role-playing activities. Anger and release of frustration occur during striking activities like bowling, paddleball, and lawn bowls. Social recreation offers opportunities for communication, cooperation, and self-control. Adventure experiences offer opportunities to enhance the self-image and develop trusting relationships while providing alternative "highs." Sports, walking, bicycling, aerobics, and yoga offer tension release, development of physical well-being, and improved self-confidence.

An important aspect of community leisure services with all participants is the management of emergencies. Substance use and abuse is manifest in a variety of individually unique ways. Through training, leisure service personnel become aware of the primary and secondary effects of substance use and abuse and first aid care for reaction and or substance overdose.

Agency policies and documentation procedures with all participants should cover medication storage and dispensation during programs. Chemicals used on site, for instance, in the pool and arts/crafts area or for cleaning, should also be monitored and secured. Additionally, when rehabilitated persons are employed or substance abusers are assigned to "volunteer" hours at recreation sites, agency policies assuring confidentiality and service project reporting to authorities must be in place.

SECTION D: EATING DISORDERS

Population Descriptors

Food addictions or eating disorders include three broad and sometimes intertwined disturbances in eating behavior. Since 1980, bulimia nervosa and anorexia nervosa have been recognized in the Diagnostic and Statistical Manual of the American Psychiatric Association as emotional disorders usually first evident during adolescence. However, the presenting age of persons with these disorders may vary from the early 20s to 60 years and older. The third disorder is compulsive overeating or morbid obesity, which is usually diagnosed by a physician and defined by a medical history of related problems.

Bulimia nervosa refers to an insatiable, ravenous appetite causing excessive eating or binging. This is followed by purging, using laxatives, diuretics, strict dieting or fasting, vigorous exercise, or self-induced vomiting to prevent weight gain. The uncontrollable binging and purging usually occur when the individual is alone. Over a several hour period of planned eating as few as 3,500 to as many as 55,000 calories of high caloric sweet or carbohydrate foods may be consumed. To be clinically defined as an eating disorder, the person must have had a minimum of two binge-eating episodes a week for at least three months.

Bulimia is more common among females than males and usually begins during adolescence or early adulthood. Persons with bulimia are usually within their normal weight range yet experience frequent weight fluctuations due to binges and fasts. Persons with bulimia experience feelings of abnormally low self-esteem and are overly concerned with their weight, body image, and appearance. Often they are depressed and may either have a family history of obesity or have experienced obesity earlier in their own lives. Because bulimia does not always result in emaciation and because the binging-purging is done in secrecy, the illness is difficult to detect. The effects of the disease can lead to heart failure or eventually death due to potassium depletion and electrolyte imbalance.

Anorexia nervosa is the best known of the eating disorders occurring predominately in females. The prevalence of the disorder has been reported to be in a range from 1 in 800 to as many as 1 in 100 females in the high-risk group of 12 to 18 years of age with a fatality rate of 10 to 15 percent of these cases due to starvation. Males account for only 4 percent to 6 percent of the disease incidence, which appears to be a phenomenon of white middle-class women.

Anorexia nervosa is a syndrome that includes self-induced starvation with an intense fear of becoming fat. Initial signs include a low self-esteem; a need to overachieve; misperceptions of hunger; grossly distorted body image; progressive preoccupation with food; exaggerated perfectionistic behaviors; frequent, compulsive, intensive exercise programs to increase weight loss; and if eating, it is usually done alone. Even though the person appears as "skin and bones" in the later stages, there remains a fear of weight gain. Mood swings, malnutrition, diminished capacity to think, incredible weakness, tooth decay, hyperactivity, hypothermia, amenorrhea, edema, and strenuous exercise lead to cardiac arrest, starvation, permanent organ damage, and death if the person does not receive treatment. Individuals may be 70 to 85 percent less than their expected weight when they seek professional assistance. Some persons with anorexia experience binging-purging as they become unable to control their voluntary restriction of food.

Compulsive overeating or morbid obesity is like bulimia except without the vomiting. Persons are at least 100 pounds over their expected weight although they see themselves as 30 percent thinner than they actually are. When anyone's weight is 20 percent over ideal for age, sex, height, and body build, there is an increased risk of mortality and morbidity.

Overeating leading to excessive weight gain may be caused by reaction to a traumatic or stressful experience such as death of a family member, or to developmental causes. In the latter case, obesity is attributed to the person's constitutional factors, emotional disturbances, and family traits of obesity and overeating. Some persons may eat less than 1,000 calories per day yet maintain obesity. This occurs because they have lowered their metabolism and increased their percent body fat while decreasing exercise. Morbid obesity is a progressive, chronic illness which may lead to complications such as arthritis, high blood pressure, varicose veins, diabetes, heart attacks or strokes, and emotional feelings including anger, withdrawal, depression, and frustration with self and others.

Functioning Characteristics

Food addiction is characterized by overdoing. Thus, it's related to food but food is not the problem. Food addicts use food to negate, cope, mask, hide, and stuff their emotions. The three primary characteristics which indicate food addiction include: 1) high tolerance for excess or rich food; 2) withdrawal accompanied by fatigue, dizziness, shaking, crying, depression, insomnia, indigestion, and memory loss; and 3) craving food after withdrawal.

Cultural norms and societal shifts contribute to a "beauty and the beast" syndrome. At any given time period, over 50 million Americans are dieting, each striving for the "ideal figure." Those who become addicted are preoccupied with food, thinness, diets, pleasing others, avoiding conflict, excessive exercising, obsessive thinking, fear of success and failure, and feeling ashamed of eating. The physical characteristics of food addiction are the most visible. The person is usually under or overweight or experiences frequent weight fluctuations of 10 pounds or more. Tooth decay, bad breath, thin, brittle, lost, or raised fine white hair on the cheeks and neck, difficulty staying warm, muscle spasms, hyperactivity, uncontrollable diabetes, degenerative arthritis, difficulty swallowing, fatigue, swollen glands under the jaw, and malnutrition as evidenced by a whitish coat on the tongue are among the most evident features of food addiction.

Tension, depression, anxiety, guilt, obsessions, and isolation are among the emotional characteristics of persons with food addictions. Inadequate emotional development is manifested behaviorally through low self-esteem, perfectionism, repressed feelings, lack of boundaries or empty feeling, nonassertive actions, punctuality, conscientiousness, self-critical or judgmental actions, feelings of loss of control, and social fear. Emotional recovery begins with experiencing feelings without the presence of excess food. Persons with food addictions tend to have family histories in which feelings were neither expressed nor encouraged, thus coping skills are limited. Recovery is a lifelong process of bridging the gap between their values and their behaviors by becoming aware of their interrelationships.

Implications for Therapeutic Recreation

People attending programs in the community may have undiagnosed food addictions or may be outpatients with eating disorder clinics. Others may be participating in such support groups as Overeaters Anonymous, either held in recreation facilities or cooperatively sponsored by clinical and community therapeutic recreators. Intervention techniques employed with persons experiencing eating disorders include various behavior modification strategies, family therapy, expressive therapies, and body image therapy. Recreators may be involved in the initial identification of eating disorders as well as in the implementation of strategies to maintain a person's participation without dependency on excessive amounts of food.

A recreator who observes a person jogging or using the weight room excessively may suspect food addiction. Likewise, a young adult at camp who displays unusual rituals while eating or who "disappears" to the restroom after meals may be suspect. The provision of family nights or seasonal special events intended to encourage all-family participation fosters communication and respect for each other which are essential in recovery. The recreation leader who encourages the participant to share feelings about an experience is fostering the linkage of feelings with behavior that is also essential in the recovery process. A sensitive leader is aware of the significance of discussions on exercise, food, and weight and attempts to minimize this focus during wellness experiences.

When the leader uses group experiences and positive reinforcement to focus on a participant's functional abilities, this increases comfort with the body and appearance. Mirror activities, art, guided imagery while relaxing, and movement experiences develop respect for the body and improve the sense of physical and emotional boundaries. Incorporating alternative food choices during leisure resource awareness experiences improves knowledge of proper nutrition. Classes on assertion, relaxation, values clarification, and stress and time management address the participant's need to regain or maintain self-control and self-respect. Leaders are sensitive to the participant's perception of them as role models representing the appropriate balance of work, leisure, nutrition, and social experiences in their daily life.

SECTION E: SEXUALLY TRANSMITTED DISEASES

Population Descriptors

Sexually transmitted diseases (STD) refer to several infections spread through personal relationships. Some, such as chlamydia, are curable with antibiotics; others, such as genital herpes and AIDS, are difficult to treat or are incurable. Persons may have more than one STD at once, as with chlamydia and gonorrhea. Also, one STD may mask a second more serious one (vaginitis masks gonorrhea) or make the person's system more susceptible to the second (herpes facilitates transmission of the virus that causes AIDS).

Chlamydia is the most prevalent STD with between three and four million people infected yearly. Gonorrhea, the most commonly reported STD, infects an estimated one million people per year. The number of reported syphilis cases has declined while estimates of oral herpes may be as high as 50 million people, with 30 million people reported to have genital herpes. Other common STDs include HPV infection, trichomoniasis, pubic or crab lice, and NSU or nonspecific urethritis.

It is estimated that 1 to 1.5 million people in the United States may have HIV infection. The person with AIDS (acquired immune deficiency syndrome) is in the final stage of an infection attributed to a virus transmitted through sexual contact and shared use of intravenous needles. HIV (human immune deficiency virus) may persist ten or more years without evident symptoms. The final stage of HIV infection, AIDS, is diagnosed by the appearance of certain illnesses that attack people whose immune systems are weak, or "opportunistic" infections. Since its identification in 1981, AIDS has spread rapidly, already causing death in more than 60 percent of the known cases.

Chlamydia is more prevalent among those under 30, while 60 percent of the reported cases of AIDS have occurred in persons between 25 and 40. A fetus may become infected with HIV before or during birth, or after birth through breast feeding, and there is an alarming increase in the number of infants with HIV.

Most persons with STDs remain in the community seeking medical assistance once clinical complications become evident.

Functioning Characteristics

Because symptoms of an STD may not be evident, a person who is carrying the disease agent may unknowingly transmit it to a second person. The most common form of transmission is through sexual contact, when the disease element is passed from one mucous membrane to that of the other person.

Chlamydia. Symptoms of chlamydia, if present, in women include pain on urination, vaginal discharge, and lower abdominal pain. Men experience a burning sensation with urination and fluid discharge from the urethra. Without care, reproductive system infections and sterility result.

Gonorrhea. Symptoms of gonorrhea, if present, include pain on urination and vaginal or penile discharge. When untreated, arthritis, dermatitis, and heart and reproductive problems result.

Syphilis. Left untreated, syphilis is fatal. In its first stage, lasting two to six weeks, a painless sore (chancre) appears on either the vagina, cervix, vulva, mouth, or penis. Signs of the second stage, occurring six to eight weeks after exposure, include swollen lymph nodes, skin rash, hair loss, or flu-like symptoms. In the final stage, the heart and central nervous system are affected. In addition, the newborn child of a mother in the final stage of syphilis may either not survive or have birth defects.

Genital herpes. Symptoms of genital herpes vary from one person to another and the first occurrence may even go unnoticed. In subsequent recurrences, lesions and painful blisters may be accompanied by swollen glands, fever, and head and muscle aches. Vaginal discharge, abdominal pressure, bleeding in the mouth, pain in the legs and genital areas, fever, and irritability are signs of oral and/or genital herpes. Fatigue, stress, diet, and trauma may cause recurrence. If untreated, cervical cancer may be one outcome.

HIV. Clinical symptoms of HIV infection may not be present for 8 to 10 years, during which time the person infected with HIV may unknowingly transmit the virus. When symptoms become evident, they may include swollen lymph glands, recurrent fever, night sweats, weight loss, tiredness, decreased appetite, cough, and shortness of breath. In the final stage, AIDS, a person's immune system is weakened and susceptibility to several diseases results. These include various forms of cancer, pneumonia, tuberculosis, and viral infections that may cause blindness or lesions on the brain.

Implications for Therapeutic Recreation

When clinical signs of an STD become evident, isolation may result due to the social stigma of the disease and fear of the unknown on the part of the general public who are lacking information. Isolation from family, friends, and work leads to depression, insecurity, reduced self-worth, and unclear role responsibilities. This social isolation and reduced physical energy may limit active leisure pursuits.

Several program management policies may alleviate fears of participants, staff, and the general public. Policies and universal precautions should be in place for areas like gyms, pools, and locker rooms. For example, medical clearance to swim or use exercise machines may be required when open sores or wounds are present. Medical approval to participate in fitness programs protects anyone, including persons with STDs like genital herpes, whose symptoms are exacerbated by fatigue. An accident protocol specifies procedures to manage open wounds. When staff assist with dressing, toileting, or cleansing protective hand and face gear may be worn. Handwashing is a necessary activity when serving food or assisting in the rest room.

Recreation opportunities need to be broad in scope as persons with STDs have varying degrees of exposure to recreation experiences. Experiences must include opportunities to demonstrate control, choice, and self-direction. Stress management, proper diet, exercise, and rest habits should also be included. Social interaction that occurs during team sports, table/board game tournaments, current events discussions, and outings is needed by the person with an STD as well as caregivers. Program sessions may need to be autonomous so participants may drop in and out when their health permits.

Leisure education strategies enhance awareness of activities that contribute to feelings of self-worth. Participants develop skills to access resources and select activities that have value and interest. Participants gain skills that improve their ability to communicate their needs to significant others.

Social and physical needs dominate the concerns of children and youth with STDs. The therapeutic recreator identifies ways in which participants may express their fears and frustration and remain a part of important social groups. Camping and adventure skills offer social outlets and challenges that bring peer recognition. Organized youth activities result in valid social relationships.

SECTION F: AT-RISK POPULATIONS

Population Descriptors

There are many persons to whom the term "at-risk" might be applied at some point in their respective lives. Commonly identified persons are children and adolescents of teenage mothers, unstable families, single parents, persons in poverty, homeless persons, and persons who have been abused. Youth at-risk come from divorced families, dual-career homes, foster homes, and various ethnic populations. The products of at-risk environments include: gang youth, runaways, latchkey (self-care) children, academic underachievers, dropouts, prostitutes, substance abusers, delinquents, poor rural children, youth suicides, and youth with disabilities. Adults considered at-risk include: persons in lower socioeconomic classes, unassimilated ethnic persons, dual-wage earners, persons who may neglect or abuse their children, single parents, homeless persons, and adults who are mobile and sporadically employed. These persons either lack or do not have access to the resources or social support networks necessary to cope or manage in complex psycho-social environments. Their world lacks security, structure, consistency, and recognition. Stress increases and persists, manifesting into negative behavior patterns and breaking down coping abilities. An additional source of stress is time; idle time may be used in activities causing crime, pregnancy, drug abuse and other self-abusive behaviors.

Estimates of the numbers of persons defined "at-risk" vary. At least 15 percent of all persons are estimated to be below the poverty level while more than 30 percent of the persons in black and Hispanic populations are believed to be below the government poverty level standard. Estimates of parents at risk of maltreating their children range from 2 to 10 percent or three out of every 100 children. More than one-half of the school age children will live in single-parent homes prior to high school graduation. Estimates of the number of children who are either left alone or in the care of an underage sibling for a significant portion of the day vary with age; elementary and high school age youth are estimated to be between 15 and 18 million while older youth estimates are higher. Between 1960 and 1980, the portion of mothers employed full-time in the labor force increased 40 to 50 percent. This phenomenon is expected to continue as more families become either dual-career or single-parent households.

Why at-risk populations? A cyclical pattern is observed: abusive parents were abused as children or children abusing drugs have parents who were alcoholics. The demography of America is changing. A larger portion of the population is older and culturally and racially nonwhite. Diversity, complexity, isolation, and economic restraint are increasingly causing physical and mental stress. Children are "easy targets" for frustrated and confused adults. Persons who are disabled or have experienced abuse are at high risk of re-abuse due to their own insecurities and inadequate coping responses. A missing parent role model or inappropriate modeling due to peer pressure leave persons without avenues to acquire essential adult life management skills, such as how to gain further education or employment.

Funding cutbacks during the 1980s reduced availability of leisure to at-risk populations, and public departments instituted new fees or entrepreneurial activities to offset declining revenue bases. These adjustments reduced access to leisure thus limiting another avenue to fulfill needs. When fundamental needs remain unmet problems arise. These problems manifest themselves in negative coping strategies and behaviors.

Functioning Characteristics

The characteristics of persons at-risk are nonspecific, that is, they may be indicative of a variety of other needs or issues. In natural settings where recreation occurs they are more evident than in the "doctor's office." The repeated display over extended time periods of several consistent behaviors is a warning of impending negative coping patterns or detrimental behaviors toward someone else.

Children and youth who have been physically, sexually, and/or emotionally abused and/or neglected may exhibit several signs including bruises, welts, abrasions, burns, bone fractures, punctures, malnutrition, internal injuries, and brain damage. Additionally, these persons may have a sexually transmitted disease, speech disorder, or eating disorder, become pregnant, abuse drugs, and/or attempt suicide. A therapeutic recreator may notice these youth resisting adult contact or displaying an unwillingness to participate. Fatigue, restlessness, and listlessness may be accompanied by such behavioral extremes as aggressiveness or withdrawal. Inability to function in a group, low self-esteem, and either overly mature or immature responses are also characteristic of these youth. Developmental and mental growth lags result from continual abuse and neglect.

Children left in self-care (latchkey) and those of single and divorced parents experience various degrees of emotional trauma reflected in their behaviors. Increased anxiety, loneliness, boredom, fear, depression, and diminished academic achievement are evident among latchkey youth. Younger children experiencing divorce show regression in self-control, self-care, and mental development, which may be accompanied by anxiety, sadness, irritability, and quickness to anger. Older children attempting to cover up their frustration and feelings of helplessness may direct their anger at a convenient target like the recreation leader. In a single-parent household, youth may assume peer relationships with their parents. This creates an emotional bond that makes parent-child separation difficult. Behavioral consequences of this relationship evident in youth include a lack of assertion, spontaneity, and decisiveness.

Primary concerns of persons with limited social-financial resources are basic needs like hunger and safety. Consequently persons, for example, who are homeless or have different cultural backgrounds are more concerned about "living well today" and are characterized as apathetic and fatalistic in their views. Fear, hostility, intimidation, and rivalry characterize neighborhoods of persons with varying cultural backgrounds. Limitations in the English language and reading skills prevent participation in traditional leisure experiences like card and table games. Invisible cultural differences like interaction style, family structure and socialization practices, and fundamental beliefs influence recreation participation. For example, a game that either eliminates players or focuses on one participant may offend a participant whose culture is family oriented.

Implications for Therapeutic Recreation

Management of therapeutic recreation programs with "at-risk" populations is as important as the actual content and leadership. Staff must be aware of the legal aspects of social issues, how to identify supporting factors and behavioral manifestations, proper reporting and documentation, and potential for illegal activities during the recreation experience. Staff must have knowledge of laws governing substance abuse, neglect and abuse of children, and activities of under-age youth like curfews and employment regulations. Staff training may include how to identify behaviors or environmental conditions that indicate abuse or contribute to illegal acts. Personnel policies should include procedures used to report and document suspected abuse or drug overdose. Lastly, personnel must monitor the employment setting whether it's a camp, playground, park, pool, or building to assure that users do not experience vulnerable situations caused by, for example, poorly maintained shrubs or unmonitored hallways.

Advisory committees represent the community where recreation occurs. A cadre of human service personnel on such a committee addresses the multiple needs of at-risk persons. Additionally, members are sensitive to the invisible significant cultural mores of their respective communities. They may serve as role models, advocates, and conduits to needed resources. Persons who have been rehabilitated and those with access to legal and governmental information are viable committee candidates along with residents of various interest groups.

With persons at-risk, the term "accessibility" takes on a new, broader meaning. Additional concerns are financial requirements, resource location, facility layout, and information availability. Participation barriers may be caused by user fees or requirement of specific clothing and equipment. A pool located in a suburban area may be "off limits" to the city resident or a center in one neighborhood may be considered "closed" to persons of another ethnic community. Facility layout and arrangement of vegetation and natural areas may contribute to unsafe experiences.

Where and how recreation programs are publicized is important to consider. Radio and TV announcements may need to be presented in English, Spanish, and Asian languages.

Street-side bulletin boards rather than facility-centered boards and newsletters may reach more participants. The words used to advertise programs must be sensitive to users and key supporters. For example, use of the word "sex" or "gang" to present programs intended to serve pregnant or delinquent youth might deter participation while alarming the general public.

The manner in which the leader interacts with the consumer is just as critical as the selection and implementation of activities. Recreation settings offer informal opportunities to communicate troublesome issues. When a leader responds in a nonjudgmental, empathetic manner yet states the expected behavior in a clear, concise, firm, consistent manner, support and security are perceived. Structure and feedback are essential during delivery of services. Disapproval is of the behavior not the person. Anger and frustration are acknowledged yet redirected. Practice in realistic goal setting and decision-making occurs as participants assist in program selection. Supportive listening without patronizing or giving advice to insoluble problems allows participants to validate their feelings and actions. The leader serves as a role model in setting achievable goals, assuming responsibility to meet the goals, and following through to assure tasks are completed. Leaders are acutely aware of the meanings implied by their gestures and words.

Therapeutic recreation may occur during programs having such titles as teen awareness forums, developmental after-school programs, survival strategies for working wives, or multicultural interaction seminars. Such programs are offered by human service agencies as well as recreation departments. Objectives of these programs include the development of independence, coping strategies, self-care skills, and travel, money, and emergency management. Participants develop comfort in being alone and not feeling bored, guilty, or fearful. Creative activities encourage release of tension. Group activities support collaboration, identification, and equalization. Focus is not placed on winning, elimination, or display of talent. The leader encourages participants to accept authoritative figures while making choices and decisions with which they are comfortable.

Recreation with persons who at some time in their life are considered at-risk is multidimensional. Experiences are educational, social service, and therapeutic. Responsibilities of staff extend beyond direct leadership to training recreation personnel, parent education, legal referral and placement, and consultation with psychiatrists and social workers. Settings also go beyond the recreation center to foster homes, day-care centers, company board rooms, and church basements.

SECTION G: LEARNING DISABILITIES

Population Descriptors

Persons with various learning disabilities participate in recreation at sites serving the general public as well as at specialized programs and centers. A learning disability is not visually apparent to the casual observer. Upon closer scrutiny three out of four persons with a learning disability will appear clumsy and awkward. Other frequently cited characteristics are: hyperactivity, perceptual motor impairments, emotional instability, attention disorders, impulsiveness, memory and thinking disorders, academic failure, and language disorders. The accepted definition of a learning disorder was published in 1968 and is stated as a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language which is manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic (Sherrill, 1986).

There is a significant discrepancy between a person's actual performance and the potential to perform in academic subjects. Therapeutic recreators become involved when the following occur: a leader complains of a "clumsy player" on a sports team; a participant who has been unsuccessful in school brings frustration to activities conducted by the leader and is labeled a "trouble-maker"; or parents seek assistance so their child will be better able to play with others or be on the school extracurricular teams. The number of children estimated to have learning disabilities is over 40 percent of those in special education (Sherrill, 1986). Nearly eight million persons under the age of 18 have been diagnosed as having specific learning disabilities. Terms used to describe these learning disabilities are as follows: dyslexia, inability to read; anomia, inability to name objects, persons, and activities; dysphasia, language symbolization disorders; dyspraxia, partial loss of ability to perform purposeful movements; dysgraphia, writing impairments; and agnosia, loss of ability to recognize objects.

Functioning Characteristics

The therapeutic recreator is most concerned with the socioemotional and motor functioning of persons with learning disabilities. Common socioemotional deficits include inadequate social perception, self-esteem, and body awareness. By adolescence many have experienced academic failure, which contributes to feelings of rejection, lowered frustration tolerance, and limited social-emotional support. Because they have difficulty comprehending the meaning and significance of others' behaviors, their social adjustment is poor. A lack of understanding of one's body also leads to negative social consequences; to illustrate, a child who hits others but is not aware of really how hard makes enemies when attempting to find friends. Learning problems lead to rejection and limited social-emotional support.

Motor deficits include hypo and hyperactivity, distractibility, dissociation, perseveration, spatial orientation disturbances, and clumsiness due to apraxia (Sherrill, 1986). The person may exhibit either too much (hyper) or too little (hypo) physical activity. Distractibility interferes with attending to a leader's directions or completing an arts and crafts project. With dissociation a person is unable to perceive the whole; only small parts are identified. Thus, completing a leather belt or remembering the square dance sequence may be difficult because the outcome is not apparent to the participant. Perseveration causes the participant to continue to repeat an activity after being requested to stop or to experience difficulty moving from a circle to a line formation. Poor spatial orientation causes a person to have difficulty following the leader's directional cues, such as to move right or left.

Persons with the same learning disability may not necessarily display the same functional abilities. Therefore, if the leader is generally aware of what to expect from these participants, adaptations to the program can be made. For example, knowledge that a participant is dyslexic enables the leader to use verbal or graphic directions rather than written materials; or knowledge that a participant is dysgraphic allows the leader to modify the written registration process to include oral reporting of information. The activity given in Exhibit 3-1 demonstrates the difficulties experienced by persons with learning disabilities.

Implications for Therapeutic Recreation

The activity content is as critical as the use of specific leadership techniques. Structured group experiences enhance social awareness and maturity. Mirror activities assist with the improvement of one's self-image. Creative movement exercises contribute to spatial awareness and coordination as do obstacle courses and gymnastics. Table and board games facilitate acquisition of academic skills as well as requiring attending skills and following directions.

Specific leadership techniques include the following:

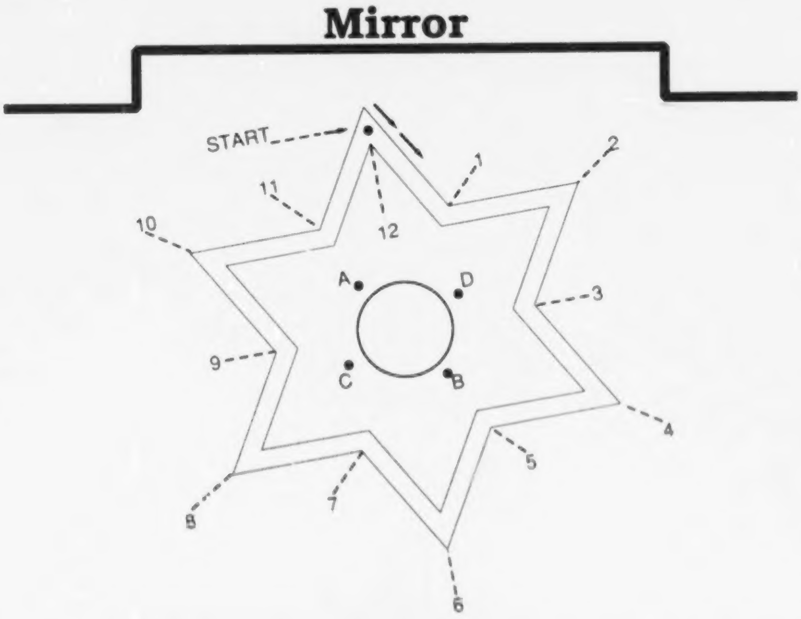
1. Organize the activity area, placing excess equipment out of sight.
2. Define the time and space requirements of the experience.
3. Eliminate excess noise or people.
4. Require participants to remain seated while waiting their turn so others are not distracted.
5. Use play objects of a different color from the background to aid distinction between the play item and the playing surface.
6. Stress overlearning of skills with several tasks or sequences to compensate for the tendency to dissociate parts.
7. Use games with a definite beginning and a definite ending to encourage transition rather than perseveration.
8. Provide a relaxation or debriefing period following an activity to foster self-control.
9. Foster patience, repetition, praise, and assurance of success through participation.
10. Refocus participant's attention by saying name after attention has gone astray (may be caused by the most insignificant item, such as a bird or car horn).

Therapeutic recreators may offer programs directly to participants with learning disabilities and/or facilitate their integration into community programs. Therapeutic recreators may discover that a person with cerebral palsy also has a specific learning disability. Characteristics of persons with learning disabilities, although less visually apparent or dramatic, are similar to those displayed by persons who are autistic and emotionally disturbed.

Exhibit 3-1

EXERCISE TO ILLUSTRATE EFFECTS OF A LEARNING DISABILITY

Place paper on a flat surface. Place a mirror on the horizontal line facing the reader at a 45 degree angle. Using the nondominant hand and looking at the mirror, trace the star as you see it through the mirror, attempting to stay within the lines. Notice how many times the outside line is touched. The difficulty experienced during this activity simulates the difficulty experienced by a person with a learning disability.



A learning disability is not visually apparent

SECTION H: AUTISM

Population Descriptors

Community services categorize children with autism as severely impaired. After school programs, summer day services, and special weekend activities in cooperation with local school districts provide essential ongoing intervention.

This syndrome is behaviorally defined. Primary characteristics include the following: manifestation prior to 30 months of age; disturbances in developmental rates and/or sequences of speech, language, and cognitive capacities; abnormal responses to sensory stimuli; and the inability to relate to people, events, or objects. Autism occurs about once in every 2,500 children, affecting four to five times more boys than girls. Autism is both a biological and a psychological disorder with causes listed as metabolic imbalance, an endocrinological deficit, and a central nervous system (CNS) disorder.

The word "autism" is derived from the Greek word "autos" meaning "self" and is interpreted to mean withdrawn and self-absorbed. Before the age of two, children with autism may appear to be developing normally although parents later recall that the expected signs of love and awareness of "mother" and "father" were not displayed. As babies they became limp or rigid when held, stared at lights, disliked lumpy foods, did not reach for objects, and, either gradually or abruptly, may have stopped walking or talking. Developmental deviations include reciting numbers without first being able to count or walking without first crawling. Children with autism are not necessarily mentally retarded, although their test scores are often very low due to their inability to be tested in a conventional fashion.

Functioning Characteristics

Children with autism appear physically normal and are often attractive. They demonstrate self-stimulatory behavior with repetitive movements, such as rocking, hand flapping, spinning objects, staring, pulling thin pieces of string from clothing, and twisting sticks before their eyes. Difficulty sleeping, hyperactivity, inappropriate laughter and giggling, avoidance of human touch, lack of eye contact, and nonexistent or peculiar speech patterns characterize their behavior. Avoidance of human interaction, resistance to change, inappropriate attachments to objects, lack of a startle response, teeth grinding, walking on their toes, muteness, echolalia, smelling, licking, eating nonedibles, poor control of pitch, volume and intonation, failure to develop and understand abstract concepts, and lack of ability to use language socially are among more commonly displayed behaviors. These youth have been referred to as "scatter children" meaning their developmental skills may be above, below, or equal to that expected of a child of the same chronological and mental age. Their behaviors tend to be out of sequence or bizarre rather than immature.

A lack of play and social skills and severe language disorders are distinguishing traits. To communicate, these children bite, kick, scream, or grab people or objects. People are treated indifferently and interchangeably. Regardless of who a person is, the child may accept an extended hand while simultaneously perseverating on an object held in the other hand (Carter, Van Andel, & Robb, 1985). Inappropriate play with objects may include fixation on a particular feature, such as a buzzer, or inappropriate use of the toy, such as spinning the wheel of a toy tractor continuously with constant eye contact on the wheel.

Children with autism appear void of affect. Interpersonal contact is closed off by their physical positioning away from others, their idiosyncratic activity with inanimate objects, and their self-abusive behavior, such as hair pulling, when someone intervenes. They are oblivious to real danger, such as the height of a tree during a climbing escapade. Yet, some develop unusual fears of tactile and auditory stimuli. Some appear to enjoy the sound of a siren, yet dart aimlessly about when hearing bells ring (Carter, Van Andel, & Robb, 1985). They are undersensitive to pain and temperature but oversensitive to touch. Perceptual motor skills, balance, and visual-motor coordination are poorly developed.

Their intellectual levels range from severe retardation to above average intelligence. Manipulative skills and rote memory tasks are strength areas. Nearly one-half of these children, especially those with mental retardation, never gain useful speech. They use single words to communicate meanings and speak labored phrases in flat, hollow tones. Older youth remain anxious, continue to have odd mannerisms or "flapping" behaviors, especially when upset or excited, and are unable to engage in imaginative activities or work or play with others in a cooperative manner. Hyperactivity may decrease with training but the ability to communicate, use symbols, follow commands, or relate to others continues to be limited.

Implications for Therapeutic Recreation

The needs of participants with autism are a mere guess as they do not respond to questions or volunteer their wants. Their coping mechanisms of avoidance, withdrawal, or abusiveness must be replaced or substituted with safe outlets, such as striking a target or hiding under a tent. They need to generalize and transfer skills without reversing the pattern or sequence. A functional language must be developed. Activities in their strength areas (numbers, mechanics, and music) can be used to encourage verbalization.

Behavior management skills consistently applied help to extinguish inappropriate behaviors but leaders must be tolerant of insignificant behaviors. Self-stimulating behavior is redirected to drum banging or marching to music. To gain eye contact the leader might need to grip the chin or place a hand on the shoulder (done with discretion). The establishment of a routine, a structured environment, and nonverbal instructions facilitate involvement.

Through therapeutic recreation participants improve their motor skills, gain control over sensory input, acquire ADL skills, and comprehend cause-and- effect relationships

Young adult explores nature through the senses

(Carter, Van Andel, & Robb, 1985). Construction toys and robots honor their mechanical abilities. Verbal activities, such as puppets and drama, encourage communication. Mirror usage allows participants to see their movement skills.

SECTION I: PHYSICAL DISABILITIES

Introduction

The nature of physical disabilities is quite diverse. This section considers those disabilities traditionally categorized as neurological, neuromuscular, orthopedic, seizure disorders, physical impairments, mobility limitations, and other locomotor disabilities. Physical disabilities are more visually apparent than are either mental or emotional disabilities. These physical disabilities may be congenital, acute, or traumatic and may result in temporary or permanent lifestyle adjustments (chronic).

Cerebral Palsy

Population Descriptors

Cerebral palsy is the medical term which refers to several neuromuscular conditions caused by damage to the motor areas of the brain, most frequently occurring before and during the birth process. A primary characteristic is motor dysfunction with the retention of primitive reflexes, such as the hand grasp reflex and the asymmetrical tonic neck reflex, so that movements appear to be uncontrolled and without purpose. Persons with cerebral

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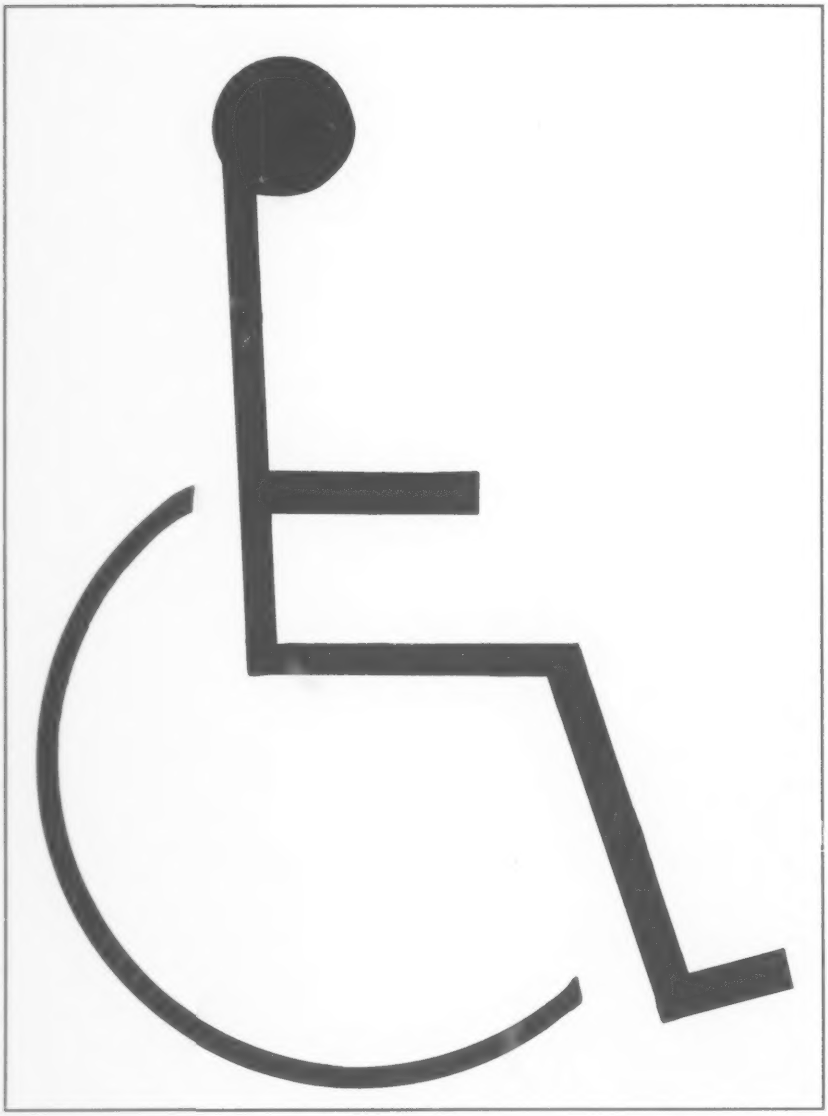

International Symbol of Access

This symbol tells a handicapped person, particularly one using a wheelchair, that a building or facility is accessible and can be entered and used without fear of being blocked by architectural barriers. It should be displayed only on those buildings intended for public use. Used throughout the world, the symbol is recognized for its special meaning.

palsy also have secondary impairments which affect their life and leisure experiences. Primary among these are inadequate communication, visual and hearing deficits, emotional instability, lack of concentration, perceptual-motor limitations, seizure disorders, perseveration, hyperactivity, distractibility, and varying degrees of learning disabilities. Cerebral palsy is most commonly associated with males, the Caucasian race, and the firstborn (Sherrill, 1986). Participants in community therapeutic programs are often of school age and are classified by Public Law 94-142 as orthopedically impaired. In the community adults with cerebral palsy often become involved in sports programs sponsored by the National Association of Sports for Cerebral Palsy (NASCP) and for these events are classified by their functional ability (see Exhibit 3-2). Preparation for "CP" games is becoming as popular in the community as Special Olympics.

Exhibit 3 - 2

THE NATIONAL ASSOCIATION OF SPORTS FOR CEREBRAL PALSY — CLASSIFICATION

Class 1: Uses motorized wheelchair
Class 2: Pushes wheelchair slowly with feet and/or arms
Class 3: Uses arm pushes to propel wheelchair
Class 4: Propels wheelchair with strong arm pushes
Class 5: Ambulates with assistive devices with spasticity in limbs
Class 6: Ambulates without assistive devices, poor coordination
Class 7: Ambulates well with some spasticity in limbs
Class 8: Ambulates without limp but displays coordination problems

Persons with cerebral palsy may be identified by the following: 1) degree of involvement; 2) anatomical impairment; and/or 3) motor dysfunction (medical classification). The degrees of involvement are presented as the following: mild, a person who ambulates unassisted and requires little treatment; moderate, a person who uses crutches, cane, or walker to ambulate and may require assistance from supportive health specialists, such as physical and occupational therapists; and severe, the person who uses a wheelchair and requires assistance from communication devices, such as lap boards, or uses sign language to communicate.

Persons with cerebral palsy have one or more body parts affected. Paraplegia affects the lower limbs. Hemiplegia affects either the entire right or left side. Triplegia affects three limbs, usually the legs and one arm. Diplegia affects primarily the legs with some involvement in the arms. Monoplegia affects one limb. Quadriplegia describes impairment in all four limbs.

The American Academy of Cerebral Palsy has developed a medical scheme identifying six types of impairment. They are as follows:

Spasticity. This is the most common form of cerebral palsy although most persons with cerebral palsy do experience some degree of spasticity. The primary characteristics are tense, contracted muscles resulting in jerky movements with flexed joint muscles, a scissors gait characterized by walking on the toes, and severe muscle contractures.

Athetosis. The second most frequent form of cerebral palsy is characterized by constant, uncontrollable motions that intensify with excitement. The head is often held back, drooling occurs, and lordosis (hollow back) is present.

Ataxia. This term describes balance and proprioceptor deficits. The person appears clumsy or experiences difficulty negotiating obstacles, inclines, or steep grades.

Rigidity. This term describes the person who is rigid and appears to have lead-pipe stiffness and inelasticity. Body parts appear hyperextended with severe curvature of the spine. There are often mental deficits.

Tremor. A constant pendular shaking, most often in the arms and hands, characterizes this form of cerebral palsy.

Mixed. This term is used when a person displays characteristics of more than one type. Most commonly, spasticity is seen with athetosis and persons are identified as being severely or multiply involved.

Functioning Characteristics

The secondary impairments of persons with cerebral palsy affect their behavior. Contractures, seizures, visual and auditory deficits, and scoliosis compound the affects of the primary motor dysfunction. Assessment of cognitive ability is limited by motor and communication impairments; therefore, the true mental capacity of some persons cannot be determined. Communication and language deficits also limit the capacity and avenue to learn. Perceptual-motor limitations affect the ability not only to ambulate but also to be creative. For example, a person who does not discriminate figure-ground or spatial relationships will have difficulty drawing a picture with a three dimensional effect.

Limited mobility affects social-emotional development. Persons with cerebral palsy do not experience the same social opportunities as persons who ambulate and/or who can communicate without assistive devices. The presence of awkward movements and disfigurement which may accompany cerebral palsy causes the person to be stared at, treated differently, and avoided. A lowered self-concept results from a lack of social reinforcement and public uncertainty and skepticism. Ability to care for one's self is hampered by lack of hand, arm, and leg control. The artificial devices used to help ambulation add extra weight causing fatigue to occur more quickly. Constant uncontrolled movements of the limbs also cause fatigue. Fine motor coordination and perceptual motor movements are difficult as are sustained movements and activity in a noisy or stimulating environment.

Primary caregivers may be required to assist the participant with ADL skills into the participant's adult life. Emotional independence is difficult to achieve under these conditions.

Cerebral palsy limits the expression of feelings, "self," wants, and needs. Age-appropriate social behaviors may not develop if participants are overly dependent on their family and aren't exposed to the social experiences that occur as one develops. The inability to express the "self" also closes off social outlets.

Implications for Therapeutic Recreation

Therapeutic recreators must be aware of the need to adjust resources, leadership, and the environment to the functional abilities of participants. A working knowledge of the accessibility standards of the American National Standards Institute (ANSI) and of the state of residence is essential. A therapeutic recreator must be familiar with the infant reflexes that are retained into adulthood and that adversely affect participants' motor patterns. Additionally, awareness of muscle relaxant and anticonvulsant drugs prescribed for seizure disorders is important. During initial contacts leaders and participants must establish a communication system. Knowledge of how orthopedic devices are used and their special positioning features is required prior to moving participants. Controlling temperature variations and noise levels, allowing larger amounts of open space, and substituting slower/softer equipment minimize muscle tension. Permitting intermittent rest periods and ending activities prior to fatigue prevent undue stress.

The needs of the participants vary according to the degree of motor involvement. Therapeutic recreation activities should be chosen which facilitate development in key areas. A primary need is to relax contracted muscle groups using activities such as rhythm and swimming. Flexion-oriented activities which reinforce contractures, such as weight lifting or kicking, should be avoided. Recreation performed from a stationary position, such as bowling, shuffleboard, track and field, archery, and table tennis, have carry-over value. Activities that require parallel movements, such as the use of an adult three-wheel bicycle, facilitate perceptual-motor training and generalized body strengthening. Improving participants' motor abilities enhances their self-care skills, which in turn fosters independence and a positive self-concept.

Persons with cerebral palsy participate in activities from seated positions

Muscular Dystrophy

Population Descriptors

Muscular dystrophy (MD) is a group of conditions resulting in progressive muscular weakness caused by the degeneration of muscle fibers. Degrees of impairment vary, but usually the earlier the onset, the more rapid the progression of the disease. The three conditions having the highest incidence are Duchenne, facio-scapular-humeral, and limb girdle. Most persons with MD are between the ages of three and thirteen; eight out of ten are male. Approximately 250,000 persons have MD (Sherrill, 1986). Muscular dystrophy itself is not fatal. The secondary complications from the weakened respiratory muscles result in infection causing death.

These diseases vary in the age of onset, the initial muscles attacked, and the rate of progression. The most common and the most serious form is Duchenne which accounts for 85 percent of all MD. Males are more frequently affected with onset between the age of two and ten or eleven. The muscles of the pelvic girdle and lower back are initially affected, followed by the shoulder muscles and muscles of the lower limbs. Degenerating muscle tissue is replaced by fat and connective tissue, which gives the appearance of bulk and contributes to the misperception that the participant is not really weak. This condition is referred to as pseudohypertrophy. Muscle deterioration results first in a waddling gait, followed by frequent falls, wheelchair use, and complete bedrest.

Facio-scapular-humeral is the most common adult form of muscular dystrophy, affecting both genders equally. Symptoms don't appear until adolescence or adulthood with a prognosis for a normal or near-normal lifespan. Muscles in the face and shoulders are affected first, leaving an expressionless condition to the face and difficulty in raising the arms over the head. Limb-girdle appears in adolescents and adults, affects both genders equally, progresses slowly, and is similar to facio-scapular-humeral except that it does not involve the face. Limb-girdle causes difficulty in raising the arms and walking due to the weakness in the shoulder and hip-girdle. Eventually the upper and lower limbs are involved.

Functioning Characteristics

As muscle degeneration progresses, mobility, self-care, social independence, and emotional well-being are affected. Children with muscular dystrophy are described as being socially and emotionally immature, lacking in self-confidence and motivation, and having a tendency to be overly dependent. Intellectual functioning is not affected by the disease, except that the person experiences reduced exposure to cognitive stimulation due to limited mobility. Regardless of the extent of involvement, prolonged physical activity is detrimental.

The complications experienced with muscular dystrophy result from a progressive inability to be active due to degeneration of muscle fibers. The loss of the ability to walk, contractures causing severe pain, postural difficulties resulting in scoliosis, obesity, and weakened thoracic muscles increase susceptibility to respiratory infections and pneumonia. Exposure to dampness or extreme temperature changes also heightens the possibility of contracting infections. Because of the weakening of the muscles of the shoulder and hip girdle, lifting, transferring, and carrying participants must be done with caution and is made more difficult by the excess weight or bulk. This may contribute to further inactivity as caregivers and professionals are more hesitant to remove participants from the wheelchair during activities.

Implications for Therapeutic Recreation

To slow the progress of muscle atrophy, activities exercising specific muscle groups should be used, such as throwing and kicking activities which use the arms and legs. Range of motion exercises with stretching and flexion-extension counter the muscle contractures. Blowing and breathing exercises assist the thoracic muscles to remain as healthy as possible to delay onset of respiratory failure. Aquatic activities encourage endurance, strength, and use of thoracic muscles important to breathing. Mental, table, and board games use cognitive skills, permit socialization, and have carry-over value as the participant regresses from self-ambulation to complete bedrest.

Wheelchair left behind during sailing outing

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Multiple Sclerosis

Population Descriptors

Multiple sclerosis (MS) affects adults rather than children and results in physical incapacitation caused by the disintegration of the myelin cover of the nerve fibers throughout the body. The myelin is replaced by scar tissue which does not transmit messages as does normal nerve tissue. MS is often mistaken for other illnesses because the symptoms are varied and unpredictable. There are periods of intensification and remission early in the disease which could last from two to three weeks or as long as five years. The disease more commonly affects women. The prognosis varies. Some persons have long periods of remission with partial or complete recovery. Typical symptoms include: transiently impaired vision, physical weakness, spasticity, ataxia, tremor, inability to control bowel and bladder, and speech and swallowing problems. During late stages participants experience mood swings from euphoria to depression, cannot tolerate heat, fatigue easily, and display signs of intellectual deterioration.

Functioning Characteristics

Persons with multiple sclerosis experience the following physical changes: eye movement is rapid; speech is slower, slurred, and sometimes staccato; a staggered gait, numbness, extreme weakness, loss of balance, and stiffness with loss of function in lower limbs that feel heavy is common; facial muscles are weak; limbs appear uncoordinated; and progressively severe tremors interfere with motor tasks. The disease is complicated by secondary impairments including contractures, decubitus ulcers (pressure sores), chronic urinary tract infections, seizures, and severe spasticity in lower limbs. Spasticity and tremor prevent walking devices from being used, diminish the person's ability to care for self, and ultimately necessitate a wheelchair for mobility. The ability to learn and retain new information is impaired. The rehabilitation process is complicated by the uncertainty of the course of the disease.

Implications for Therapeutic Recreation

Range of motion exercises, swimming, and stationary bikes provide avenues to strengthen muscles, teach walking patterns and relaxation, and improve breathing capacity. Also, these activities encourage integrated leisure experiences. The pace of activities may be slowed with intermittent rest periods. The leader needs to support and encourage the participants to remain active when they experience periods of depression and low motivation. The rehabilitation process is supported by requiring participants to use their shoulder and arm muscles to practice transferring themselves in and out of a wheelchair and to propel their wheelchair. When persons are using wheelchairs, arm push-ups and pressure lifts counter the development of pressure sores. Exercises done from a seated position aid body mechanics and posture. Family leisure encourages mutual support while educating caregivers and participants about available leisure resources.

Spina Bifida

Population Descriptors

Spina bifida originates during the first month of fetal development; as of yet it is not known why this occurs. Spina bifida is a defect in the spinal column caused when one or more of the vertebral arches fails to close around the spinal cord. The three types of spina bifida are categorized by the extent to which the spinal cord protrudes through the opening in the vertebral column.

Spina bifida occulta occurs when the vertebrae of either the lumbar or sacral areas remain open at the spinous processes; the spinal cord is unaffected. The only outwardly visible sign might be a mole, a tuft of hair, or a dimple in the skin above the vertebrae. These persons are capable of participating in community recreation programs.

Spina bifida meningocele is the term used to describe the condition resulting when there is a protrusion (cele means tumor) of the covering (meningo) of the spinal cord (myelo) through an opening in the vertebral column. Surgery is done after birth to close the lesion. Persons with this form of spina bifida may also participate in community recreation programs with very little limitation.

Spina bifida myelomeningocele or MM is the most severe and most common form of spina bifida. The spinal cord actually protrudes through the spinal column and the body's surface. The covering, the spinal cord, and the nerve roots are exposed, resulting in the loss of bowel and bladder control and the use of the lower limbs. Approximately 90 percent of these children are also hydrocephalic; this is caused by the accumulation of cerebrospinal fluid within the cranial vault. If not corrected, the head becomes enlarged. A shunt is inserted behind the right ear to drain the fluid into the right atrium of the heart. Hydrocephalus may result in brain damage, causing mental retardation and perceptual motor disabilities. These children may be obese and have skin lesions and deformities of the spine and lower extremities. Spina bifida is the second most common disability of school-age children after cerebral palsy.

Functioning Characteristics

Below the lesion, the person has no sensation, does not sweat, and is susceptible to bruises, burns, cuts, or freezing without feeling as the incident occurs. When a lesion occurs, poor circulation slows healing. There is a high incidence of scoliosis and kyphosis. Wearing a wrinkled sock or putting wet feet in dry shoes may cause a blister which could lead to very slow healing decubitus ulcers.

Special procedures are used to urinate. The most common procedure is catheterization; a catheter or tube is inserted through the urethra into the bladder to drain urine at controlled time intervals. This same procedure is used by persons with spinal cord injuries.

Developmental delays and postural deformities are common. As a result participants may wear long leg braces or back braces and/or use wheelchairs. These braces, like wheelchairs, decrease the participant's level of activity and require the leader to make adjustments in the pacing of the activity. Some persons who normally ambulate with crutches may select to use a wheelchair during recreation activities since this gives them more freedom to move about. Intellectual capabilities are not affected unless hydrocephalus is present. Social-emotional delays result from frequent hospitalizations and surgeries as a child.

Implications for Therapeutic Recreation

Participants need to develop upper arm, shoulder, and torso strength to assist in wheelchair mobility, breathing, and maintaining of correct posture. Stretching and strengthening the lower limbs prevent contractures. Swimming builds strength while aiding in mobility and weight control. Developing skill in activities which can be done from a seated position, such as ceramics and bowling, fosters integrated leisure experiences.

Certain precautions must be taken during recreative experiences. If a participant has a shunt, direct blows to the chest area could dislodge the device and necessitate medical attention. Poor sensation and circulation in the lower limbs causes extensive bleeding and slow healing of even slight injuries, such as those received during transfer in or out of the wheelchair or by rubbing of the skin against rough surfaces. Leaders must become familiar and comfortable with catheterization so assistance can be offered during public outings or while camping and in a manner that facilitates normative experiences.

Children with spina bifida may have full intellectual capability while ambulating with a wheelchair

Activities that strengthen the upper torso facilitate participation in wheelchair sports

Convulsive Disorders

Population Descriptors

The terms epilepsy, seizure disorders, and convulsive disorders are used interchangeably to describe a neurological condition caused by abnormal transmission of electrical current through nerve fibers in the cerebral cortex. The resulting condition is a sudden change in consciousness or behavior characterized by involuntary motor activity. This disability often begins during childhood; nearly 70 percent of all persons with seizure disorders initially display evidence of seizures before age 21; the remaining 30 percent have their first seizure after age 40. Roughly one person out of every 150 to 200 persons has epilepsy; over 80 percent of these persons have their disorder controlled by anticonvulsant drugs such as Dilantin, Phenobarbital, Mysoline, Tegretol, Depakene, Zarontin, and Tridione. Seizures complicate such disabilities as cerebral palsy and mental retardation. Causation of a majority of seizure disorders is unknown. Acquired epilepsy results from brain damage, birth injuries, head injuries, poisoning, anoxia, high blood pressure, and infections.

The International Classification System adopted by the World Health Organization in 1970 identifies four broad seizure categories determined by the amount of the brain involved. Partial seizures (focal) are focused on one area of the brain and may or may not result in loss of consciousness. Jacksonian is the most common and is characterized by clonic or jerky contractures that begin in one part of the body, like the hand, and continue up the limb until all muscles are involved. Psychomotor or automatism seizures are characterized by unexplainable short-term changes in behavior usually not remembered by the participant. The behavior may be aggressive or antisocial in nature.

Generalized seizures involve the entire cerebral cortex and describe several types of seizures, including those traditionally labeled petit mal and grand mal. Absence (petit mal) seizures or short seizures are characterized by a dazed appearance, amnesia, cessation of mental processes, and upward rolling, staring, or jerking of the eyes. Among children, these seizures are more common in girls, last less than 30 seconds, are rare before age three, and generally disappear by puberty (Sherrill, 1986). Tonic-clonic (grand mal) seizures are the most common and severe of the generalized seizures and are easily recognized by the loss of consciousness with tonic (continuous, stiff, rigid) muscle contractions and clonic (jerky) movements. A warning or aura may precede the seizure. Loss of bowel and/or bladder control may also occur. After the seizure, the person is very tired and generally will rest or sleep. A grand mal usually lasts no longer than two to three minutes followed by a few minutes to several hours of sleep.

Also in the category of generalized seizures are the following: myclonic—very brief, sudden, violent muscle contractions in one part or the whole body, such as the head or arms and legs, with or without loss of consciousness; atonic seizures—causing a brief loss of postural tone with a tendency to gag or collapse; akinetic seizures—causing a momentary loss of consciousness with sudden loss of muscle tone and falling to the ground; and infantile seizures—occurring between three and nine months of age and causing the body or a portion thereof to double-up, commonly associated with severe mental retardation.

The other two seizure categories of the International Classification System are unilateral and unclassified seizures. Unilateral seizures occur on one side of the brain and body and may be any of the above listed types. Unclassified seizures are either mixed or don't meet any one of the above criteria.

Functioning Characteristics

If a seizure disorder is not the result of acquired brain damage or a secondary complication associated with emotional, physical, or mental disabilities, the person functions in the normal behavioral ranges. The stigma associated with having a seizure and the dramatic nature of a tonic-clonic seizure tend to cause negative social responses. Age of onset, frequency, duration, type, and severity influence the functional abilities of participants. The presence of anticonvulsant medication in the blood stream impedes motor functioning, which then impacts social, emotional, and intellectual skill development and use. Persons, especially children, who experience frequent, long-lasting seizures miss "learning time" and social exposure, thereby falling behind in the development of age-appropriate skills. The emotional trauma associated with the reactions of others to a seizure influences the formation of negative feelings toward "self" and perceived "differences."

The physical location of some activities, such as in a pool, arts and crafts area, or outdoor environment, necessitates the therapeutic recreator's attention to the danger associated with seizures. A fall caused by any of the types of seizures may result in injury, such as needing stitches to the head or a cast to set a broken wrist.

Staff who interact with persons known to have seizures should be familiar with the warning or aura which may precede the seizure, such as a reported faint or dizzy feeling, a peculiar smell or sound, or a strange momentary body movement. If a seizure continues beyond its normal time period and is followed by one seizure after another the condition is called "status epilepticus" and requires immediate qualified medical attention. Certain situations precipitate seizures and may be influenced by : activity levels, blood alkalinity and sugar levels, emotional stimuli, hyperventilation, excess noise or flashing lights, physical fatigue, lack of sleep, head trauma, alcoholic beverages, and the menstrual cycle.

Implications for Therapeutic Recreation

The nature of seizures has direct implication for some activity forms. Activities in which a blow to the head could result, such as diving, soccer, or the use of a trampoline, require supervision. Hyperventilation resulting from running or swimming is to be avoided. There is a need to develop fitness, strength, and endurance to counter seizure-induced fatigue. Through leisure education, participants become aware of the positive relationship between activity and seizure control.

Persons whose seizures are controlled by medication may carry on routine leisure activities. Therapeutic recreators provide training to other recreation staff on how to modify and lead safe and appropriate activities. All staff should know how to respond to seizures if they occur (see Exhibit 3-3). Staff should keep themselves updated on the side effects of seizure medications. Arrangements for storing and dispensing medication during activity periods should be made.

Exhibit 3-3

LEADERSHIP PROCEDURES WITH SEIZURE

1. Remain calm and stay with the participant.
2. Anticipate an "aura" or sign, such as a stare, head jerk, or report of "seeing stars" or "hearing a sound."
3. Permit the seizure to run its course which may be a few seconds to a few minutes.
4. Do not restrain or move, only protect, the participant; prevent injury by removing objects and people.
5. Do not force a blunt object between the teeth.
6. Loosen restrictive clothing around the neck, arms, and waist.
7. Turn the head to the side for release of saliva or vomitus; protect limbs that may be hitting hard surfaces.
8. Remember that during the seizure the participant hears those activities and voices in the immediate environment.
9. Allow the participant to rest after the seizure; confusion may be present for a while and thus the participant should be monitored until rational behavior returns.
10. Repeat directions and instructions since a blank stare may indicate that the person has had a seizure, causing the person to miss the directions.

Spinal Cord Injuries

Population Descriptors

The vertebral column or backbone is comprised of 33 bones. There are seven cervical (C1-C7), twelve thoracic (T1-T12), five lumbar (L1-L5), five sacral (S1-S5), and four coccyx (see Exhibits 3-4 and 3-5). The spinal cord runs from the brain, through the spinal (vertebral) column, and ends at the L1 level vertebra. The function of the spinal column is to protect the cord and support the body. Injury to the spinal cord from disease or trauma results in both motor and sensory impairments. The extent of the disability is determined by the level at which the damage occurs and the severity of damage to the spinal cord. Injuries may be either complete or incomplete. If the nerve fiber cells are completely destroyed, no recovery of function below the level of injury will occur. A partial or incomplete lesion results from bruised, torn, or crushed nerve tissue in the spinal column and causes only partial damage to functions below the injury level with some recovery possible.

Quadriplegia is caused by damage to the spinal cord in the neck area to the cervical vertebrae, C1 through T1, and causes the loss of function in all four limbs and the trunk. Mobility, even with a wheelchair, is difficult as is respiration and sitting independently. Movement of the neck and arms is limited and talking may be labored. The use of respirators and electrical chairs and carts is common.

Paraplegia is caused by damage to the spinal cord below T1 and causes the loss of lower limb function. Persons who are paraplegic may also have cerebral palsy, muscular dystrophy, birth defects, spina bifida, or have experienced a vascular accident. A paraplegic has the use of the neck, shoulders, arms, and hands. The lower the level of the lesion, such as T9-10-11 as compared to T2-3-4, the greater the upper body strength, lateral stability, and functional mobility. A paraplegic may ambulate with crutches or a wheelchair or may choose to use a wheelchair only during activity and extensive travel.

Spinal cord injuries (SCI) affect males between the ages of 18 and 30 more than any other age group and are caused by automobile accidents, gunshot wounds, diving, and work-related accidents. The most common injury sites are middle-to-lower cervical, C5-6, and thoracolumbar junction, T2-L1. Nearly half of the SCI injuries are complete, resulting in total loss of the following: voluntary movement and sensation below the injury level; bladder, bowel, and sexual functioning; and control of the sympathetic nervous system which affects heart rate, blood pressure, and temperature control.

Functioning Characteristics

Spinal cord injuries do not affect cognition or thought processes; however, the emotional overlay caused by the trauma of the incident may result in unclear thoughts. Physical capability is dependent upon the location of the lesion and the degree of completeness. There will be impairment in all of the following functions: personal hygiene,

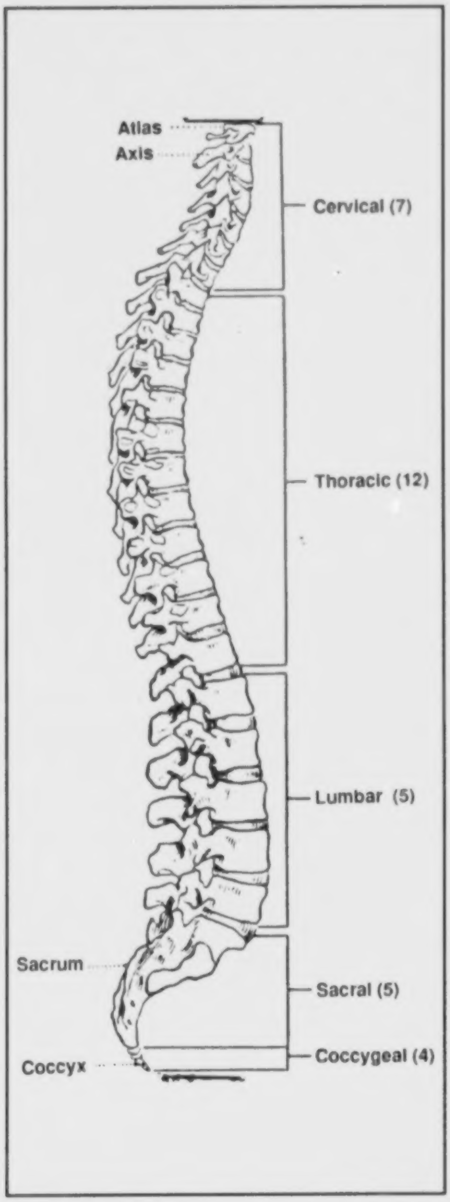

Atlas
Axis
Cervical (7)
Thoracic (12)
Lumbar (5)
Sacrum
Sacral (5)
Coccygeal (4)
Coccyx

Exhibit 3-4
The vertebral column viewed from the right side

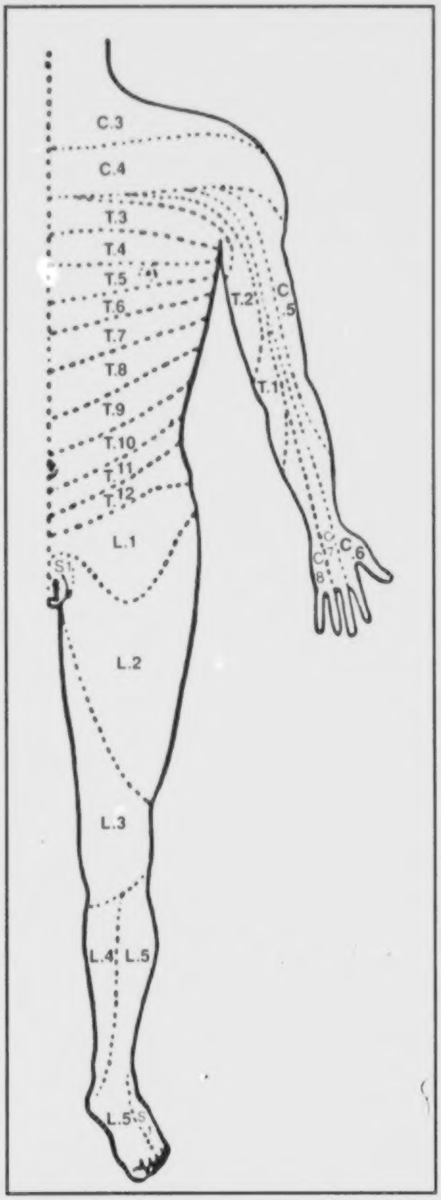

C.3
C.4
T.3
T.4
T.5
T.6
T.7
T.8
T.9
T.10
T.11
T.12
L.1
S1
T.2
C 5
T.1
C 6
C 7
C 8
L.2
L.3
L.4
L.5
L.5
S

Exhibit 3-5
Spinal cord innervations in extremities

ambulation, transfers, dressing, eating, writing, and automobile driving. The elimination processes are also affected; therefore, catheters, urinary bags, ileostomies, and colostomies are common. With impaired sensation comes insensitivity to heat, cold, pressure, and wetness causing complications, such as bed sores. There is also loss of tactile perception, severe pain caused by muscle spasticity, and generalized body atrophy attributable to decalcification of the skeletal system. Reduction in the ability of the abdominal muscles to function properly affects respiration and causes secondary problems, such as pneumonia. Persons with incomplete lesions may experience scattered muscle control throughout the body with sensation in peripheral areas and the lower extremities. These persons also may experience more spasticity and pain than persons with complete lesions. This may inhibit their muscle functioning. A person with incomplete paraplegia may have no sensation or muscle control in the thighs yet complete return of sensation in the lower legs and feet and be able to ambulate with little or no assistance.

The psychological impact of the trauma or disease causing the paralysis may manifest itself in denial, depression, apathy, resentment, hostility, dependency, approval seeking behaviors, and grief, such as that associated with the loss of a loved one. Social and personal adjustments must be made because of the interruptions in work and family roles, the economic cost of the disability, the loss of sexual functioning, and the social inconvenience accompanying loss of bowel and bladder control.

In community settings, there will be participants who were recently injured and are just getting into activities, such as swimming, and those who were injured longer ago and have been involved for some time in activities, such as wheelchair sports. How well the person cares for self, sets realistic goals, and complies with the leader's directives are reflective of the extent to which the person has adjusted to the change in lifestyle.

Implications for Therapeutic Recreation

The therapeutic recreator helps the participant to learn independent leisure functioning skills. The participant needs to learn to be comfortable emptying bowel and bladder bags, to avoid experiences that would bruise or damage the skin, and to strap the legs either to the wheelchair or to each other to deter muscle spasms. Practice negotiating accessibility obstacles aids re-integration into the community. Practice with a "sport" wheelchair fosters independence.

Weightlifting and chair sit-ups or push-ups develop upper torso strength. Negotiation around obstacles encourages participants to develop balance. Swimming, riding a quad-bicycle, and hand pedaling a stationary exercise bicycle improve endurance and breathing capacity. Outings with family and friends support awareness of leisure resources as well as realistic self-assessments. Video games, computers, and table and board games offer alternatives to activities requiring standing and are appropriate leisure skills. Wheelchair sports competition encourages renewed self-interest and social access.

Basketball is one of the more popular sports with athletes using wheelchairs.

Head Injuries

Population Descriptors

Head injuries are the leading cause of death for persons under the age of 34. Most of these persons are involved in traumatic accidents or are injured by gunshot. Infections, tumors, toxic agents, lack of oxygen, lesions, and swelling (edema) also damage the brain and result in a disability. The age at which the injury or illness occurred; the severity, magnitude, and location of the lesion; and the premorbid condition (condition of individual prior to injury or illness) influence the extent of the disability, the course of functional recovery, and the performance level regained. Temporary or long term changes occur in consciousness, sensation, cognition, personality, motor ability, and emotions. The functional level of persons with head injuries is similar to persons who have had a stroke or CVA (cerebral vascular accident). Damage to the right side of the brain results in left-side impairments. Also, the psychosocial and cognitive effects are similar to those experienced by persons who have had a stroke.

The participants in the recreation program may come from the spinal cord/head injury unit of a local hospital, may be brought by family members, or may come with other residents of a group home. The majority are male. The recovery period for head injury may be lengthy; consequently, participants will exhibit varying levels of motor ability, perception, memory, sensation, reasoning, and emotional lability. Outward appearance may be deceiving. Traumatic injuries may result in little or no visible damage to the head, yet a wheelchair must be used for mobility. Likewise, visually apparent lesions may result in minimal motor restrictions.

Functioning Characteristics

The extent of permanent brain damage is partially determined by the age of the person at the time of injury. The younger the person, the better the prognosis. With a young person the brain tends to compensate with the left side taking over duties of the damaged right side and vice versa. The more brain tissue damaged, the higher the probability of significant disability. Likewise, the longer the coma or loss of consciousness, the greater the probability of significant disability. Premorbid abilities, personality, social/cultural environment, and lifestyle influence prognosis. Positive adjustment to the disability is more likely to occur if the person, prior to injury, was healthy, well-educated, and possessed a strong self-identity.

An injury to the left cerebral hemisphere results in impairment to language and comprehension. When presented with a new situation, the person's response is slow, scattered, disorganized, and anxious. Motor and sensory paralysis of the right side of the body is most evident. Right hemisphere damage results in paralysis of the left side of the body and impairments in judgment and visuo-perceptual functioning. These persons tend to be self-centered, overestimate their abilities, deny their impairments, and are less sensitive to the needs of others.

Secondary complications are also similar to those experienced by persons who have had CVAs. Depression, contractures, spasticity, seizures, visual neglect, emotional lability, memory losses, deficits in attending skills and the ability to generalize, and the effects from medications, such as Valium and Dantrium, complicate a participant's adjustment. Participants experience difficulty dealing with abstract concepts, fatalistic attitudes may be present, and behaviors and language use may be inappropriate.

Paralysis occurs suddenly with a traumatic injury but more gradually with a tumor or brain disease. Amnesia affects the participant's memory of previously enjoyed leisure activities. Resistance, irritability, limited verbal capacity, and decreased inhibitory controls require leaders to be patient and not to be too surprised at what is said.

Implications for Therapeutic Recreation

The therapeutic milieu is as significant to the participants as the actual experience. Staff, the location of the activities, and the schedule should remain consistent. Structured small-group experiences, a limited number of objects, and extra space for movement facilitate involvement. To compensate for tactile defensiveness the participant is told of an impending touch and activities with various textures are employed. To compensate for visual neglect, the leader must stand more directly to the front, rather than to the side, of the participant. Reality orientation techniques offset disorientation. Range of motion exercises counter contractures. Safety cues alert participants to where their body parts are in relation to themselves and the space around them. Seizures may disrupt activities. The loss of feeling may interfere with the accurate assessment of obstacles in the environment.

Leaders learn to expect the unexpected. Praise, repetition, patience, confrontation, firmness, and behavior management describe a leader's interventions. A leader accepts that participants may be impulsive, inflexible, indecisive, lack initiative and foresight, and quickly forget their newly acquired skills. Activities are chosen to encourage participants to develop endurance and coordination and to express their frustrations or denial. Activities with family members serve to support and educate caregivers and to encourage social interaction.

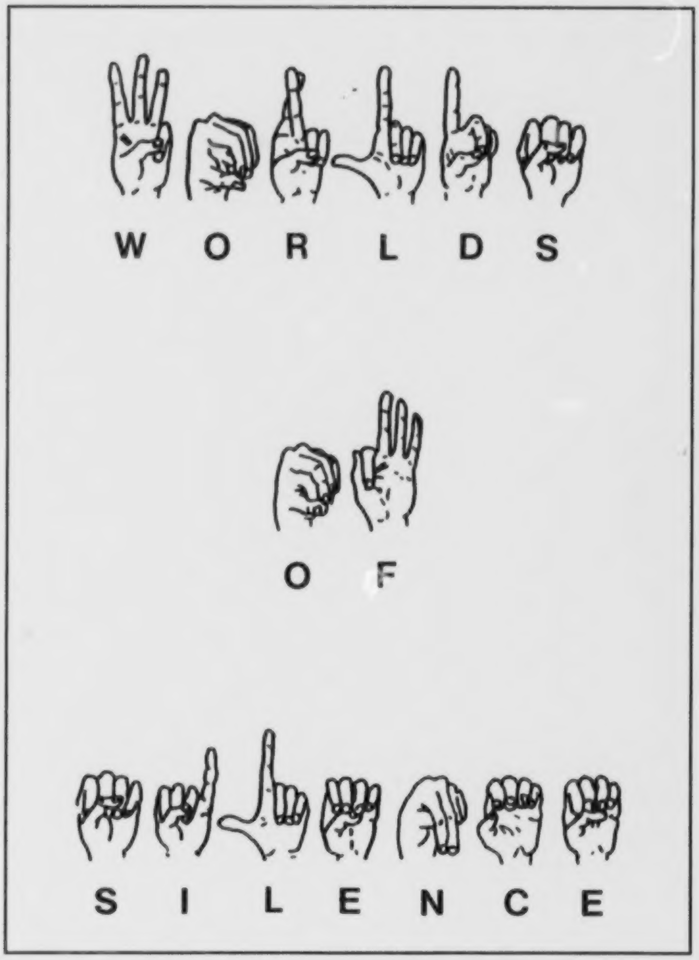
Hearing Disabilities

Population Descriptors

Hearing disabilities occur with varying degrees of hearing loss. A deaf person cannot hear or understand speech well enough to converse. Persons who are hearing impaired can, with assistance, understand speech enough to communicate verbally. The degree of hearing may also be defined by loudness (measured in decibels, "db"), scale, and pitch or frequency (cycles per second, expressed in Hertz, "Hz"). The participant's age at onset affects the amount of disability; the earlier the loss, the more severe the consequences, especially if the impairment is congenital. If the loss occurs before the age of three, prelingual language development is affected. When hearing loss occurs after the age of three (postlingual), the person has some language base on which to build. Congenital loss may be due to hereditary, disease, or unknown (idiopathic) causes. Acquired losses result from accidents, illnesses, and disabilities. There are nearly 15 million persons with hearing disabilities in America; 5 to 7 percent of all school-age children have auditory problems.

Functioning Characteristics

Persons with a profound hearing loss can hear only loud shouts while those with a slight hearing loss hear everything except faint whispers. Hearing loss may be greater at one frequency than another; for example, a person may hear lower pitched voices better than higher pitched voices. Loss of hearing distorts feedback from the environment so persons may have difficulty appropriately adjusting their movement, such as when walking or jogging. The person with a hearing disorder may have poor posture and a shuffling gait. If the disability is due to inner ear problems, balance and agility may be affected. Persons with hearing disorders tend to associate with others having the same disability. This results in limited social interaction and leisure opportunities. Depression, fear of situations which might result in danger, anxiety in large groups, confusion,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frustration, and social isolation can lead to loneliness, boredom, and feeling rejected, which lead to a lowered self-concept and self-confidence.

Implications for Therapeutic Recreation

The leader adjusts the leadership techniques, the programming area, and the activity to accommodate the functional levels of participants. Leaders must remember to enunciate, face the participants, eliminate background movements and distractions, and place themselves in the participants' direct line of vision. Use of gestures, visual aids, and guided discovery techniques brings concreteness to abstract concepts. Hearing devices may need to be removed during activities, such as with activities involving either fast movements, moving objects, or water. Presentation of the activity in an organized, structured manner encourages participant comfort with the experience and better communicates the leader's expectations. Staff must remember to teach the participant what procedures to follow in case of an emergency.

The leader needs to incorporate experiences that encourage socialization and the development of balance, coordination, rhythm, and perceptual motor patterns. Hyperactivity during the activity may result from the frustration of not hearing; thus, as few verbal directives as possible should be used. Participants should be encouraged to actively participate. Card, table, and board games require less verbal interaction than play production. Relaxation and movement exercises encourage reduction of muscle tension. Cooperative activities, new games, arts and crafts, and adventure courses foster fundamental social skills. Modification of swim strokes so that a participant's head is not completely under water helps build confidence in the water. Outings provide a time to practice the safety skills which will give them increased access to integrated recreation resources.

Visual Disabilities

Population Descriptors

Visual disabilities range from severely limited to the total absence of vision (blind); however, even the legal definition of blind allows for some residual vision. A person who is legally blind, with corrective lenses, sees at 20 feet what a sighted person sees at 200 feet in the better eye or 20/200. A person who is partially sighted has vision between 20/70 and 20/200. One commonly used educational scheme identifies a visually disabled person as one who can read print and a blind person as one who is not able to read print. The major causes of visual disabilities are infectious diseases, accidents, poison, tumors, prenatal causes, and conditions associated with aging. At least two-thirds of those with visual problems are over the age of 65 (Sherrill, 1986). Children are less frequently affected by this disability than by any other disability, except multi-handicaps or deaf-blind. Visual losses may occur in acuity (sharpness of vision), adjustment to light, field of vision, central vision, or peripheral vision. Congenital blindness is present at birth; adventitious blindness occurs after birth.

Functioning Characteristics

The age of onset and the degree of residual vision are the primary determinants of functional ability. Behavioral characteristics generally exhibited by persons with visual disabilities include the following: a forward lean of the body; a tendency to be obese due to a lack of movement and exercise; a rigid or stiff walking pattern; poor perceptual motor skills; inability to orient self to the surrounding environment; expressionless face; insensitivity to the feelings of others; slow motor development; a poorly developed self-image; and "blindisms," such as rocking motions and digging at the eyes, which may be attributable to frustration due to their inability to move about freely. Cognitive functioning is limited because of reading and communication deficits. Social-emotional development and expression are restricted by limited movement. A lack of initiative, low self-confidence, fear of movement, dependency on others to assist with movement, and a tendency to verbalize without being able to monitor voice loudness and quality are also present. Some persons tend to minimize their visual disabilities by attempting to be more independent than they are actually capable of being.

Implications for Therapeutic Recreation

Modifications in the activity, setting, leadership, and resources facilitate participant involvement. Before an activity commences, a communication system, including emergency procedures, is established. Next, the leader must orient each participant to the area, to objects in the area, and to the location of the other participants. Providing color and surface contrasts encourages independent activity as does the use of sighted partners, audible balls, and tactile guides. Other leadership approaches include the use of demonstration with guided discovery, whole-part-whole teaching, and placement of the participants' hands on the leader's body parts as activities are modeled or role played. The leader should verbally inform the participants when entering or exiting an area to eliminate surprising them.

Participation in activities at a recreation center, on a camping trip, and during outings offers opportunities to acquire mobility skills needed to safely ambulate in the home, along city streets, and in buildings. Movement and range-of-motion exercises foster awareness of self in space. Rhythm, dance, and music activities offer an outlet for "blindisms." Beep baseball and goal ball offer increased endurance, gross motor skill development, and social interaction. Drama, singing, and theater provide practice in voice modulation and articulation and help to increase awareness of the needs and feelings of others. Arts and crafts, such as pottery, clay, ceramics, finger painting, and needle crafts, require participants to develop their sense of touch and their fine motor skills.

SECTION J: CARDIOVASCULAR DISEASES

Population Descriptors

Heart diseases are the leading medical problem in the United States in terms of numbers of persons affected and total cost. Over 500 thousand heart attacks occur each year with one-third of these in persons under age 65. Coronary heart disease is the most prevalent and costly. Hypertension (high blood pressure) affects over 25 million individuals and is a complication of coronary heart disease. Heart failure and atherosclerosis are two other common forms of heart disease. Participation in special exercise, swimming, or wellness programs offered cooperatively between hospitals and community recreation programs is prescribed by physicians for likely cardiac candidates or for those recovering from heart failure. All recreation personnel should be aware of general symptoms of cardiac disease; those providing direct services should understand the energy demands of various exercises and forms of recreational activity.

Functioning Characteristics

The general symptoms of cardiac disorders are as follows: difficulty breathing or shortness of breath; edema (swelling) in the feet, ankles, or abdomen; dizziness (vertigo); general weakness and fatigue; indigestion and constipation; double vision; bluish discoloration of the skin, especially in the extremities and lips; and angina pectoris (sudden and severe heart pain). There is usually no effect on the participant's mental abilities although memory may be confused or disoriented at the time of the heart attack. Denial, fear, anxiety, and depression are among the common responses to major cardiac illnesses.

Coronary heart disease is a progressive disease in which fatty material accumulates on the wall of the coronary artery resulting in a narrowing of the artery to such an extent that the oxygen demands of the heart muscle are not met. A heart attack (myocardial infarction) may result. Hypertension (high blood pressure) is detected in a routine physical exam. If not discovered, heart failure and stroke are among the possible results. Heart failure, or the inability of the heart to pump blood adequately, may occur in any form of heart disease. Atherosclerosis (obliterative arterial disease) involves the same process as that causing coronary heart disease. Upon exertion the participant experiences weakness and tight cramping sensations in the muscle not receiving an adequate blood supply due to the narrowing in the blood vessels. Most commonly affected are the arteries of the abdomen and legs.

Implications for Therapeutic Recreation

Large muscle group activities, such as swimming and walking, serve as weight control measures, tension reducers, and a means to improve fitness levels. Programs with increasingly difficult activity levels educate participants about the energy demands of various activities. Leisure education stresses awareness of diet, exercise, relaxation, and the importance of monitoring activity levels.

The therapeutic environment is as significant as the activity to participant well-being. Leader responsibilities include the following: assuring calmness, consistency, and pacing of activities; controlling ventilation, temperature, and carbon monoxide levels in the air; regularly checking pulse rate and blood pressure; monitoring lifestyle adjustments; and confronting the participant's denial or avoidance behaviors. Drugs employed in cardiac rehabilitation cause side effects with which staff should be familiar. Common side effects are transient weakness, dizziness, headache, rash, or drowsiness. Leaders must develop a sense of when to motivate or "push" participants and when to have them reduce their activity levels. One of the initial signs of nearing maximum energy output is bluish lips; yet there are some participants who experience this occurrence regardless of activity level.

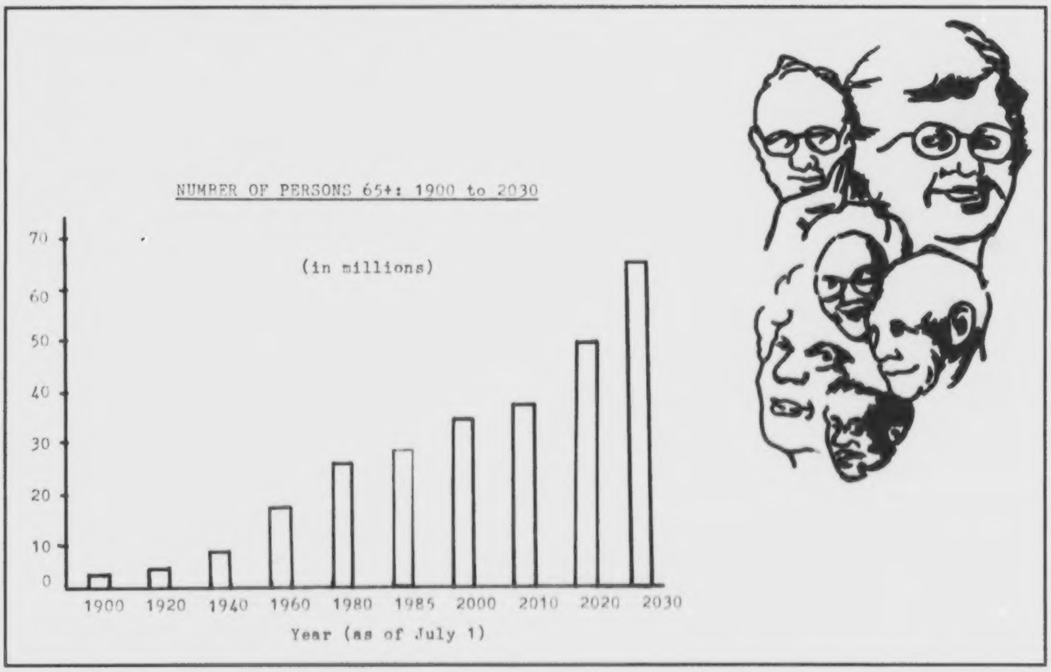
SECTION K: AGING PERSONS

Introduction

America is aging. More and more people can expect to live longer than ever before. Today the life expectancy is nearly 74 years of age. Three out of every four people who reach the age of 65 are expected to reach 75. One out of every five Americans is now 55 years old or older. By the year 2020, one out of every 3.5 Americans will be over the age of 55 and the average life expectancy will be 80. Today, seven out of ten persons over the age of 65 own their own home. Five percent of the senior population resides in long-term care facilities. Projections for the future indicate that therapeutic recreators will be programming for more as well as older community participants.

The aging process is primarily a physiological phenomenon unique to each individual. Each of us brings to the aging process a personality as well as other factors that influence how well we respond to the biological and physiological changes accompanying aging. The other factors are heredity, sex, race, environment, family, life patterns, education, economic level, employment, political power, medical care, and chronic disabilities. The major forms of illness encountered by aging persons are depression, organic brain syndrome, circulatory disorders, deafness, blindness, arthritis, diabetes, respiratory tract infections, gastrointestinal diseases, and neurological problems. Aging persons have nearly the same potential to recover from an illness as they did when they were younger. The impact of an illness is influenced by factors such as home support, motivation level, financial resources, attitudes of those close to the aging person, and the activity level of the person.

The well elderly participate in recreation at either senior centers or recreation centers under the direction of recreation leaders or senior specialists. The frail elderly participate at special centers or in recreation centers under the direction of either therapeutic recreators or senior specialists. Participants' levels of functioning range from mild limitations in activity due to arthritic joints, high blood pressure, or obesity, to moderate limitations in activity, social, and self-help skills attributable to a stroke or CVA (cerebral vascular accident), Alzheimer's disease, severe heart condition, or rheumatoid arthritis. The primary disabilities for which therapeutic recreators will program include stroke, arthritis, Alzheimer's disease, and mental and emotional disabilities. It is not uncommon to find enrolled in the same program elderly participants with a variety of disabilities. The next subsection will discuss three of the primary disabilities not presented in previous sections of the text: rheumatoid arthritis, stroke, and Alzheimer's disease.



Population Descriptors

Rheumatoid arthritis is the nation's number one crippler. Over 22 million Americans are severely enough affected to require medical care. Rheumatism refers to a group of disabilities affecting muscles, connective tissues, and joints and is evidenced by heat, swelling, redness, stiffness, and pain. Irreversible changes in the bones and joints make them stiff and, in some instances, so distorted that movement is difficult or impossible. Out of the more than 100 types of joint inflammations, rheumatoid arthritis, osteoarthritis (degenerative joint disease), and nonarticular rheumatism occur most frequently.

Rheumatoid arthritis may be systemic (affecting the entire body) or peripheral (affecting only the joints). If the arthritis is systemic, the person may feel sick all over with symptoms such as fever, rash, anemia, fatigue, and enlarged lymph glands and spleen. The joints most commonly affected are those of the knee, ankle, foot, wrist, hand, arm, and hip. The joints are characterized by inflammation, limitation of movement, muscle atrophy, and tenderness. Acute episodes flare up unpredictably, causing pain and irreversible tissue damage. Three times as many women as men are affected. Participation in activities helps the person to maintain range of motion and/or gain some relief from the pain caused by inflammation, contractures, and deformities. Two popular and beneficial programs are doing exercises from a seated position and swimming; both encourage cardio-respiratory endurance, the maintenance of strength, and muscle extension.

A stroke is caused by a disruption of the blood supply to the brain as a result of a blood clot (thrombosis), hemorrhage (ruptured blood vessel), embolism (a clot blocking a blood vessel), hypertension (high blood pressure), and/or hardening of the arteries (atherosclerosis). The effects of the damage to one side of the brain are seen on the opposite side of the body. Damage to the left side of the brain results in paralysis of the right side of the body and affects speaking, understanding, reading, and writing. Damage to the right side of the brain results in paralysis of the left side of the body and affects perceptual, visuo-spatial, and judgment abilities. Persons who have had a stroke commonly experience visual neglect and a loss of coordination and control on the affected side. Additionally, they experience weak facial muscles, aphasia (total loss of the power to use or understand words), and impaired cognitive functioning, especially of the abilities to plan ahead, reason, recall, attend to tasks, and use numbers.

The average age of onset is 60 years of age, but a stroke may happen at any age and knows no sex or socioeconomic barriers. Effects from the stroke are evident to the leader as attempts are made to motivate and communicate with participants. They may experience depression, contractures and spasticity (both of which are extremely painful), shoulder subluxation, and severe swelling and pain in the contracted muscles of the hand and arm on the affected side of the body. Difficulties in expressing and receiving verbal messages are present. Therapeutic needs of a person who has recently had a stroke are somewhat similar to those of arthritic persons. Muscle strength, range of motion, balance, ambulation practice, self-care, communication, social interaction, and bilateral activities enhance participants' abilities to remain active. These activities also assist in the prevention of hypertension and other heart conditions.

Alzheimer's disease, a progressive degeneration of the brain, is now called the disease of the century. Nearly three million Americans are affected with 7 percent of the 27 million people over the age of 65 disabled by the disease. It claims more than 120 thousand lives each year, making it the fourth leading cause of death among the elderly after heart disease, cancer, and stroke. Alzheimer's disease accounts for more than half of all cases of senile dementia. Although it usually occurs after the age of 65, persons in their 40s have been known to have Alzheimer's disease. The most common early sign is fading memory. Other signs are personality changes, anger, inability to express oneself in full sentences, apraxia (difficulty performing rote gestures, such as hair combing), and difficulty in making appropriate judgments. The disease first affects the mind, then the body. Eventually the person becomes bedfast with death commonly attributed to pneumonia.

Progress of the disease, measured by Reisberg's Global Deterioration Scale, parallels in reverse the changes a baby makes in development. Symptoms of the disease may first become apparent when the person loses a job or it becomes too difficult. This is followed by loss of the ability to maintain a checkbook, drive a car, complete household tasks, care for self, control bladder and bowel, converse, walk, or sit. Generally, a rapid onset of the disease continues in rapid deterioration; a slow initial onset continues in slow degeneration. The disease causes death in from six to eight years or a more lengthy time period.

Damage to the brain results in regular, predictable, progressive cognitive losses in the following: memory, concentration, language facility, the ability to recognize people and things, the ability to put thoughts and actions together to accomplish even the simplest tasks, and identifying who they are. These core symptoms are accompanied by secondary or associated symptoms which a leader must manage during leadership experiences. Adaptive or coping mechanisms become apparent when routine, structure, and habits are replaced by "newness." Adaptive responses include denial, seemingly purposeless conversation, perseveration, avoidance of questions that cannot be answered and situations that are painful, anxiety, euphoria, suspicion leading to paranoia, regression, and total helplessness when under pressure.

Persons with Alzheimer's disease attending therapeutic programs display characteristics of the initial and middle stages of this disease. They are forgetful; recall of specifics is lost; memory of recent events is limited and memory of past events is fading; travel in a familiar place is disoriented; words are forgotten or substituted; the ability to do prescribed exercises disappears; and denial, withdrawal, and a hopeless look produce a "flat effect." Participants must be reminded to pay attention, where to go for the next activity, to use certain equipment or clothing, to put their purse or book down, as well as how to lift their leg, touch their toe, or kick their feet.

Functioning Characteristics

The aging person experiences a longer adjustment period before returning to a state of homeostasis following activity. Pulse rate, oxygen consumption, and the ability to resume normal respiration following activity vary more greatly with age. Persons with arthritis, stroke, and Alzheimer's disease experience impaired motor movements, especially in coordination, range of motion, fine motor tasks, flexibility, and movements requiring perceptual motor and proprioceptor skills. Their walking stride may be shortened; they may walk with their feet wider apart; and they may lean forward. They may use a wheelchair or cane to assist with mobility. Movement may be stiff and painful in the affected limbs of persons with arthritis and strokes and purposeless among participants with Alzheimer's disease.

Energy is expended adapting to and recovering from stresses associated with the aging process, retirement, loss of loved ones, decline in health, lowered standard of living, and age-specific changes. Adjustment to aging is dependent upon the perception of and attitude toward this process and the illnesses and disabilities that may occur. Fear, anxiety, and helplessness are feelings that become more intense with the presence of degenerative diseases. The "self" is threatened by the physical and physiological changes. Anger, denial, depression, emotional lability, and emotional detachment are adaptive mechanisms used by participants.

Persons with heart conditions, diabetes, and arthritis are less likely to experience intellectual losses than are persons with stroke or Alzheimer's disease. Yet factors inherent in the aging process, such as visual and hearing losses, isolation, and financial limitations, impede mental activities. Senior adults are less receptive toward learning via exploration and experimentation. Conversations about the past are often more pleasing and happy. Abstract concepts, such as time, relationships, and values, may become less meaningful. Social opportunities are limited by physical, emotional, and intellectual deficits. A major deterrent to maintaining activity is the lack of accessible transportation. Families become the primary caregivers and social contacts for many elderly persons.

Implications for Therapeutic Recreation

Leaders must include in their planning consideration of noise level, temperature and light control, and accessibility of parking, restrooms, and activity areas. Structure, routine, and familiar environmental cues reduce anxiety, confusion, and frustration. A purpose of activities is to maintain current functional levels while inhibiting the debilitating effects of the disability. Community programs may serve as intermediary steps between home and long-term residential placement. Or they may serve to aid the transition from the hospital to the home following an illness, such as a stroke. Leaders must motivate, encourage, and remain optimistic, recognizing that participation levels are influenced by such circumstances.

Mobility practice, exercises aiding flexibility and muscle extension, range of motion, reality orientation, resocialization, and activities fostering relaxation and endurance counter participants' functional losses. Group holiday crafts, cooking, singing, and volunteer projects result in positive reinforcement, meaningful roles, and sharing with caregivers. Aquatic programs serve to reduce pain and stiffness. Current events programs and creative arts permit socialization and emotional expression. Leaders offering community tours facilitate access to other necessary supportive services, such as insurance and legal resources. Special events, such as Senior Games and Senior Day at the State Fair, stimulate community awareness of seniors while offering them an opportunity to display their talents.

SUMMARY

Participants in the community display a broad range of skills and needs. Within each disability category, persons exhibit varying functional levels which justify program design based on participant skill levels. The categories under which material is organized in this part represent an effort to structure a large quantity of material into usable divisions and is not intended to either label or categorize participants. Persons within community programs may display behaviors described in one category yet wear the clinical label or diagnosis of another medically or psychologically defined group.

The largest number of community participants have either mental or physical deficits with increasingly greater numbers of participants attending services designed for aging persons. Therapeutic recreators are designing follow-up and transitional programs for persons who have experienced traumatic spinal cord or head injuries and cardiovascular diseases. Fewer numbers of persons with hearing and visual disabilities are found in community programs when compared to other disability groups. Information presented under "Population Descriptors" in each category is intended as an overview or factual background about the disability. Information under "Functioning Characteristics" presents behavioral characteristics common to many of the participants identified in the particular category. The section entitled "Implications for Therapeutic Recreation" contains information applicable to the design of programs which is explained in the next sections of the text.

KEY TERMS

Acute. Illness or disability of sudden onset causing a severe limitation.

Anoxia. Lack of oxygen, often resulting in brain damage.

Anticonvulsant drugs. Medication used with seizure disorders that is intended to either reduce the severity or frequency of seizures.

Atlantoaxial. A condition associated with Down's syndrome in which the muscles and ligaments around the joint of the atlas and axis vertebrae are lax, thus allowing these vertebrae to slip out of alignment and cause spinal cord damage.

Aura. A sensation preceding the onset of a seizure.

Chronic. Illness or disability having a long term or recurring impact.

Congenital. Illness or disability existing since birth.

CVA. Cerebral vascular accident (stroke) caused by the stoppage of blood circulation to part of the brain.

Dissociation. A person is not able to perceive the whole but rather perceives unrelated small parts.

Distractibility. Inability to attend to and/or complete a project.

DRGs (diagnosis related groups). A patient classification system which groups similar ailments in order to control the length of hospital stays and thereby reduce health care costs.

DSM. Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association for the purpose of categorizing and classifying behaviors.

Echolalia. Senseless repetition of a word or sentence which has been spoken by another person.

Emotional lability. Describes a degree of fluctuation in one's moods.

Enuresis. Inability to control urination.

Latchkey programs. Programs offered to youth during time periods when caregivers are unavailable, such as following school prior to the end of each workday or during school vacations while caregivers are at work.

Perseveration. Uncontrollable repetition of a word, phrase, or gesture.

Psychotropic drugs. Medications used to control the primary and secondary effects of mental disorders that enable participants to better control their behaviors.

Reality orientation. Intervention technique used to make participants aware of the present.

Self-help skills. Similar to ADL. The ability to care for one's own personal needs.

Tics. Involuntary, repeated motor movements.

Traumatic. Sudden bodily injury with the potential of having a lasting effect.

TRAINING EXPERIENCES AND STUDY QUESTIONS

1. Read paperback books, such as Dibs In Search of Self, All My Children, Karen, Joni, Son Rise, One Child, to explore family and participant adjustment to a disability.

2. Observe participants in sensory-motor, social, and cognitive activities, such as aquatics or sports, social dance or outings, and table and board games. What characteristics present themselves that would be indicative of participant needs?

3. Interview specialists, such as speech, physical, occupational, and vocational therapists, social workers, and teachers. What do they identify as their role with participants in the community?

4. Identify a particular person with a disability and participate in a recreative experience with this person. Identify implications for the leader to consider as programs are designed as a result of your volunteer experience.

5. Compare the recreation needs of at least two different participants by observing them and interviewing them with regard to their likes and dislikes and present and past participation history. Determine the impact of their individual functioning characteristics on therapeutic recreation program content and leadership.

6. Interview therapeutic recreators from clinical, residential, and community settings to determine their roles with respect to various participants' transitions among community human services.

7. Observe participants in their home or with primary caregivers. Study these interactions to determine implications on the design of community services.

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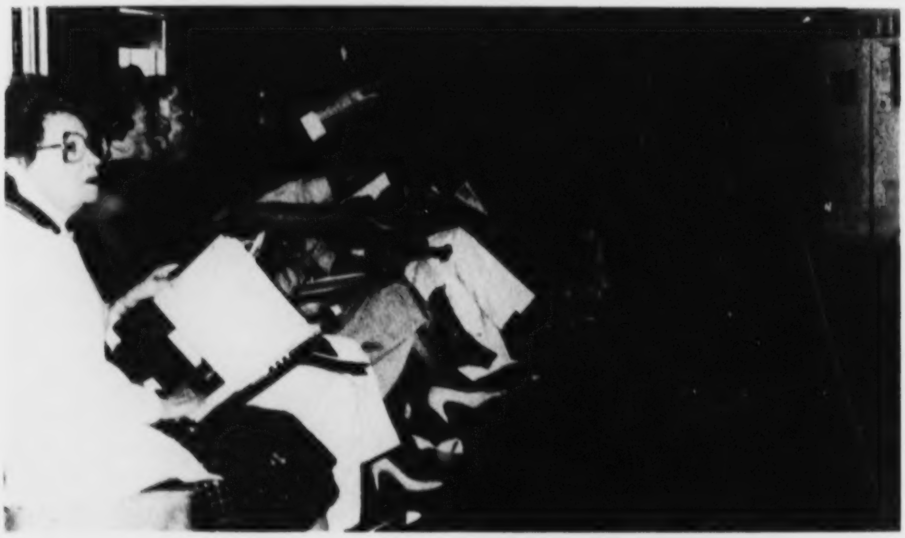
Each community is unique in the number and proportion of age groups to be serviced. The leisure services, resources, and needs determined in the assessment phase help design the appropriate program structure.



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PART III

PROGRAM PLANNING

INTRODUCTION

During the second phase of program design, planning, a series of tasks are undertaken to prepare to implement (phase three of program design) programs. Data from the assessment phase (Part I of this publication) are analyzed to determine the essential leisure needs of residents and the available resources to support the program. Staff use these data to prepare a program justification and structure, to select content and leadership processes, and to identify evaluation measures to be used during service delivery.

Two initial tasks during planning are: 1) the development of a philosophy, including a definition of a program structure with appropriate content and processes and 2) the design of a management plan. A philosophy establishes the service scope that defines the structure or form of program delivery. A management plan organizes on paper the personnel, the time, and the tasks required to prepare and operate a program. The remaining tasks undertaken during the planning phase of the therapeutic recreation process are detailed in the next section of the text (Part IV, Program Operation). All of the tasks completed during the planning phase precede program implementation or delivery. Some tasks, such as financial or personnel management, also are ongoing and critical responsibilities during actual program delivery. Each subsection of this part contains an introduction and summary to present the uniqueness of the information contained in the particular section.

SECTION A: SERVICE SCOPE

Introduction

Each community is unique with regard to its leisure services, resources, and needs. This uniqueness is determined during the assessment phase. The information gained is used to design an appropriate philosophy and program structure. Therapeutic recreation is offered under several program structures: segregated, integrated, centralized, decentralized, and combinations thereof. A philosophy statement with purposes and goals becomes the guiding directive for the program structure or model by which services are delivered. This position or "scope of service" is also influenced by the professional philosophical statement and the recreation philosophy of the administrators in the agency. The objectives derived from the philosophy and goals determine content and process. Program and participant evaluations drawn from the objectives establish measurement of service effectiveness. At the conclusion of this step, the paperwork necessary to implement a program is complete.

Philosophy and Program Structure

A philosophy is a broad statement defining program parameters. Some statements are preceded by historical data and background information collected during initial assessments. A philosophy statement presents the reason for the existence of a therapeutic recreation service. Embodied in the statement are accepted principles, definitions of terms, explanation of historical concepts and theories, and current professional practices and trends. This statement becomes the foundation and justification used by the planners as they design a program structure.

Research-based concepts giving support to community therapeutic recreation include:

1. An increase in percent of community residents with disabilities. An estimated 10 percent of the population of any given community has some limitations in their daily living activities.

2. An increasing awareness of accessibility and mobility barriers and limitations; for example, accessible mass transit and communications systems.

3. An increased awareness of all persons' legal access to programs.

4. Awareness that, without employment, persons have a disproportionate amount of daily hours free to leisure.

5. Acceptance by social service agencies and government funding sources that recreation is a primary vehicle to achieve the least restrictive environment allowing entry into the mainstream of community life.

From these concepts, the planner derives service delivery principles. The following statements are accepted program principles applicable to any community setting:

1. The normalization principle implies service delivery conducive to participation in skill and age appropriate activities designed to meet individual needs. Inferred from this principle is the use of assessment and evaluation processes to assure placement along a skill continuum according to functional ability.

2. Activities offered in the least restrictive setting facilitate participation in the mainstream of society. Use of existing agency and community services and resources is implied. A program model may consist of various combinations of segregated and integrated experiences.

3. Regardless of geographic location, type of residence (apartment, group home, private home), or available personal supportive resources, persons with disabilities are entitled to have access to appropriate leisure services and resources. This proposition encourages recognition of the need for leisure experiences on evenings, weekends, and holidays as well as during the day.

4. To function successfully within the community, persons must display adequate skills in communication, social interaction, self-care, emotional adjustment, physical well-being, and comprehension. These behavior skills become the basis for designing programs (see Exhibit 4-1).

Exhibit 4-1
COMMUNITY LIVING AND LEISURE SKILLS

Fiscal Management
Making change
Budgeting
Banking
Shopping
Physically managing money safely

Community Mobility
Types of movement: walking, public transportation, driving, bicycling, wheelchair, or go-cart
Supportive skills: stamina for locomotion, signage, quickness, judgment, telling and reading time on clocks and schedules

Social Interaction
Types of contacts: family, friends, neighbors, social and human service persons, employers, support group members, landlords, strangers, police and medical persons
Supportive skills: discrimination, assertiveness, sharing and taking turns, physical contact, noise level, advocate of needs

Communication and Articulation
Expressive and receptive language
Telephone use
Letter writing and mailing
Bill paying
Information gathering on resources such as recreation

Interaction with Establishments
Social agencies
Churches
Schools and workshops
Banks
Door-to-door sales and delivery
Health and emergency centers

Leisure Considerations
Participant preferences
Participant skill repertoire
Access to transportation, money, equipment, clothing
Permissions, consents, releases, risk management
Socially age-appropriate and or visual perception of activity
Relationship to program goals or plans
Participation contingencies such as registration, orientation or training, memberships, clearances, clothes, assessment
Formal and informal exchanges and interactions among participants, observers, passers-by, supervisors
Physical and programmatic accessibility and barriers imposed by self, others, and resources
Individualized adaptations and modifications

The title given to "therapeutic recreation" in the community has varied from "adaptive" and "developmental" programs to "special services" and "recreation for special populations." These labels are reflective of historical and professional beliefs and philosophies. The roles of service providers and recipients are often implied by the terms chosen to define a service. Historically, the place of service (setting) and the limitations of the participants tended to be the focus; thus "community recreation for special populations" was the phrase used to describe therapeutic recreation services in the community.

Also included in a philosophical statement are interpretations or definitions of key terms:

Centralized. Services and programs are provided at one site by a core staff trained in therapeutic recreation.

Community. A group of people sharing common customs and beliefs and living within a specified geographic area.

Content and process. Systems terminology used to describe the recreation experiences and the leadership techniques.

Decentralized. Services and programs are located in a number of sites with staff trained as therapeutic recreators and with community recreation employees.

Integrated programming. Activities in which persons with and without disabilities simultaneously participate.

Segregated programming. Activities offered exclusively for either persons with disabilities or for persons without disabilities.

Service continuum. A model defining programs and services by participant functioning levels with staff/participant ratios identified to facilitate goal achievement. It includes the following three service levels:

Therapeutic recreation. A 1:1 to 1:3 staff/participant ratio is needed with participants having definite leisure and social dysfunction.

Leisure education. A 1:3 to 1:6 staff/participant ratio is necessary to enable participants to acquire leisure skills and become aware of personal and community resources.

Recreation participation. A staff member provides supervision and guidance while either individuals or groups of participants practice and use their acquired leisure skills.

Therapeutic recreation. The application of selected leisure experiences through a helping relationship to facilitate participant growth and development toward total wellbeing.

An agency's philosophy may include statements similar to the above as well as a purpose statement with goals and objectives. A purpose statement briefly summarizes the scope or parameters of an agency's program. In general terms the who, what, when, where, and why are defined. The following are examples of such statements:

- To provide an opportunity to persons with disabilities to achieve a level of leisure and well-being appropriate to their abilities and interests and which is suited to their needs as community residents through individualized year-round therapeutic recreation programs offered in the least restrictive setting.

- To provide an opportunity through therapeutic recreation programs for persons with physical, mental, and socio-emotional disabilities to gain leisure and leisure related knowledge and skills so they may participate in the mainstream of the community while meeting their growth and developmental needs and achieving personal well-being.
- To provide an opportunity through therapeutic recreation programs for residents with disabilities to acquire and use those knowledges and skills which enable participation in leisure experiences of their choice and enhance their abilities to function within the community setting.
- To provide an opportunity through community-based therapeutic recreation programs for residents with disabilities to develop physical, mental, emotional, and social skills necessary to participate in a continuum of activities which enhance their well-being while encouraging family and community support.

Goal statements clarify and define the agency purpose statement. Goals written for an agency are process oriented, such as "to provide" or "to facilitate"; whereas goals written for specific agency programs are product or outcome oriented, such as "to improve" or "to increase" participant skills. Agency goals are derived from the agency purpose statement and give direction to the agency program structure.

A purpose statement normally has three to seven goal statements written to clarify its full intent. These statements must reflect assessment information, especially the constraints or limitations of the community and agency, and must be feasible or appropriate to the projected service population. Each goal statement should have a level of specificity and be written in the format of each of the other goal statements. The following are generic goal statements appropriate with any of the above purpose statements:

- To provide an opportunity for intra- and inter-agency cooperation to enhance the leisure services and resources available to residents throughout the community.
- To provide an opportunity for citizens with disabilities to develop leisure and supportive knowledges and skills enabling their participation in a service continuum of segregated to integrated programs in least restrictive settings.
- To provide an opportunity for all community residents to become aware of and support therapeutic recreation.
- To provide an opportunity for agency staff, resource persons, and caregivers to acquire knowledge and skills about therapeutic recreation so as to gain their support of and involvement in the service delivery process.
- To provide an opportunity for participants to transition among community resources and services through information dissemination.

The philosophy statement accepted by the National Therapeutic Recreation Society in 1981 is one guide to consider as the agency's program structure is developed. Its leisurability statement proposes three services which lend themselves to interpretation as either separate programs or as one continuum of service from segregated to integrated programming. This model defines "recreational therapy, leisure education, and recreation participation" as a progression of services which become less structured as the participant increases in the ability to recreate. To apply this concept to the community setting, appropriate nomenclature for the three services might become "therapeutic recreation, leisure education, and recreation participation."

The location of therapeutic recreation on the organizational chart influences the design of the program structure. Therapeutic recreation may be either an autonomous division having status equal to other departments, such as volunteers, athletics, and special events; or it may be under an umbrella with other services, such as seniors and special services. Its placement on the organizational chart influences the division's share of the financial resources and proximity to decision-makers. The more administrative levels there are the more steps and time necessary to allow for requests and through which monies must filter.

Therapeutic recreation may also be either centralized or decentralized with respect to agency facilities. The agency may offer programs community-wide within existing centers, parks, and pools, thus decentralizing services and resources with therapeutic staff functioning as trainers, advocates, and supervisors. With therapeutic programs centralized in one facility, staff assume direct leadership on-site and serve as consultants to centers and agencies in the community providing support for participants during integrated experiences. Services may also be a combination of the two with one facility offering segregated programs and other sites throughout the community offering integrated programs.

A program structure consists of services compatible with the agency organization and philosophy, the professional and political trends and concepts, and the assessed needs and resources of the community, agency, and participants. Each service is defined by its own purpose, goals, objectives, experiences, and leadership. Together the services comprise the agency's therapeutic recreation program.

A generic model consisting of the three services (therapeutic recreation, leisure education, and recreation participation) is proposed (see Exhibit 4-2). The purpose of therapeutic recreation, the first service, is to permit persons with disabilities to acquire support skills, such as communication, activities of daily living, and social skills, as well as fundamental skills enabling recreative behaviors compatible with their ability level and the community's expectations and demands. Leisure education, the second service, is designed to enable the participants to become aware of their needs, skills, resources, and support systems and to continue to develop those knowledges and skills required to function appropriately in the community. The third service, recreation participation, describes services of either a segregated or integrated nature which allow persons to exercise their acquired leisure and supportive knowledges and skills in an accessible setting with significant others.

Exhibit 4-2
MODEL PROGRAM STRUCTURE

Therapeutic Recreation

Purpose

To provide an opportunity for participants to develop and improve recreational skills, abilities, knowledges, and skills supportive of their leisure participation through individually designed experiences intended to foster independence in the community.

Goals

To provide an opportunity for participants to acquire and increase their abilities in fundamental recreation skills and in developmental, socio-emotional, and daily living functions through selected leisure experiences.

To provide an opportunity for participants to acquire those skills necessary to become self-sufficient in the daily living and social needs required during recreative experiences.

To provide an opportunity for participants to enhance their abilities to communicate their leisure needs and interests.

Leisure Education

Purpose

To provide an opportunity for participants and their significant others to become aware of their leisure assets and resources and to develop leisure knowledges and skills appropriate to a variety of community and transitional placements.

Goals

To provide an opportunity for participants and significant others to develop an awareness of their use of leisure, and the role or contributions of leisure experiences to participants, significant others, and community residents.

To provide an opportunity through inter-agency cooperation for participants and significant others to become aware of community resources accessible to their use during leisure.

To provide an opportunity through information dissemination and training of professionals to enable participants to access leisure resources and services throughout the community.

To provide an opportunity for participants to enhance their leisure skills in programs appropriate to their developmental needs and functional abilities.

To provide an opportunity for participants, through exposure to available leisure settings and services, to enhance their ability to select community leisure experiences in concert with their needs and interests.

(Continued)

(Exhibit 4-2: Model Program Structure--Continued)

Recreation Participation

Purpose

To provide an opportunity for participants to selectively participate in integrated recreational activities compatible with their interests and needs and commensurate with their abilities.

Goals

To provide an opportunity for participants to participate in progressively challenging activities selected on an ongoing basis.

To enhance the opportunities for participants to utilize recreational services throughout the community through the provision of personnel, information, and resources.

To provide an opportunity for participants to participate in age- and ability-appropriate activities community-wide through ongoing training and consultation with community agency leaders and volunteers.

To provide an opportunity for participants to use, maintain, and improve the knowledges and skills acquired during therapeutic recreation and leisure education activities.

Each of the three services (therapeutic recreation, leisure education, and recreation participation) is further clarified by program objectives. The objectives establish specific participant behaviors to be modified, improved, or enhanced. Each statement identifies one observable and measurable outcome to be achieved by program participants. Evaluation determines whether the therapeutic application of experiences and intervention processes has enabled the participant changes described in each objective.

In each service, leaders observe and measure four types of behavioral changes: physical, cognitive, affective, and social. Each of these types of behavior consists of a number of skills. The objectives describe skill changes in each behavioral area.

Physical behaviors are concerned with movement and the sensation of motion. Balance, coordination, manipulation, strength, endurance, and perceptual, fine and gross motor movements are among the behaviors to be improved during therapeutic experiences. Most experiences require the use of physical skills; however, these skills are more evident in activities such as swimming and walking than in drama or reading.

Cognitive behaviors are concerned with thinking or mental activity and can be as simple as recalling the score or as complex as creating a music script. Cognitive skills are evident during table and board games or in the strategy of team play.

Affective behaviors occur during the expression of emotions through verbal and nonverbal communication and gestures. Emotional responses range from responding to or showing an interest in a leisure project to selecting a preferred recreation experience and valuing the outcomes of a recreative experience or relationship.

Social behaviors are evident during interaction with others. Social maturity is defined by age-appropriate responses to group experiences. Acceptance of authority figures, emotional stability and control, cooperation, and sharing are exemplary behaviors.

In each of the behavioral areas, there are behaviors that are neither visible nor audible, such as "thinking," "feeling good," or "having fun." Although desirable program outcomes, these are subjective descriptors. To describe such covert behaviors, overt skills or indicator behaviors are used. For example, "having fun" is determined by observing laughing or hearing a positive response to a question such as "How do you feel about playing with the team?"

The actual number of objectives written for each of the program goals is determined by several factors. Focus of the program, be it therapeutic recreation, leisure education, or recreation participation, establishes the degree and area(s) of desired behavioral change. To illustrate, during therapeutic recreation programs the intent is to modify behavior in each of the areas; whereas, the intent of recreation participation is to allow use of newly acquired skills or practice of already present skills. Thus, more objectives with definite behavioral changes are specified with therapeutic recreation. The time duration of either the program or the participant's attendance influences the amount of anticipated behavioral change. Skill complexity, anticipated behaviors used to successfully live, work, and/or recreate in the community, and support and expectations of significant others influence the extent to which program objectives are incorporated into the program structure.

Objective statements are comprised of the following three essential elements:

1. An action verb describes an observable and measurable performance or skill to be developed or changed during a program. Words, such as run, write, talk, attend to a task, listen, maintain eye contact, take turns, or not hit or leave the group are examples of skills to be acquired during recreation.

2. The conditions or circumstances under which the behavior is developed are specified in the statement by phrases describing the time or length of a program, such as "in 14 days" or "during fall programs"; the class or activity format, such as "small group activity" or "in an arts and craft session"; and/or the equipment or resources used to learn the skill.

3. The performance level or criterion is stated by listing, for instance, the percent or number of correct times, the accuracy level, the amount of time, the number or percent of program participants, such as 70% of the participants, and/or characteristics to be observed by the leader. The criterion is set at the minimal level of acceptable performance. Considerations to be taken into account when determining the "acceptable" level of performance include the participant's entry skill level and the amount of time allotted to develop the skill; the lower the initial skill level and the less time permitted to learn the skill, the lower the level of acceptable performance. When the skill is critical to the participant's safety, a higher level of acceptable performance is necessary. Also, when the time lapse between skill acquisition and skill use will be lengthy or when the skill will be used less frequently, the level of acceptable performance must be set higher in order to retain the skill. One objective for the leisure education goals from each behavioral area is presented in Exhibit 4-3.

The writing of objectives provides the foundation for selecting the appropriate experiences and leadership. Objectives identify the nature of the activities that should be offered to enable participants to acquire desired behaviors. Once activities are selected, the leader determines which interaction and intervention processes will best enable participants to acquire the desired behaviors. Thus, the writing of objectives is a very significant phase in program design.

Exhibit 4-3
OBJECTIVES FOR LEISURE EDUCATION GOALS

Physical: During the fall program, each participant will visit at least two community-based leisure settings and report to the leader the services available from each setting.

Cognitive: After completing at least three leisure awareness activities, each participant will demonstrate an understanding of the meaning of leisure by writing or telling the leader a minimum of three to five benefits for each of two personal leisure activities.

Affective: By the end of the leisure education session, each participant will demonstrate proper etiquette at least 80 percent of the time while on a field trip into the community.

Social: During outings or field trips, 50 percent of the participants will demonstrate their ability to appropriately function as group members by remaining with the group, following the directions of the leader, assisting or helping other group members, and not laughing, talking, modeling, or mimicking those behaviors not accepted by the public.

Content and Process

Content. After program objectives are prepared, the leader must select experiences that will enable the participants to attain the behavioral changes and skills described in the objective statements. The leader must determine the most appropriate activities to use to achieve each objective. This issue is resolved by using two processes, activity analysis and task analysis, to determine the skill requirements and skill difficulty of potential activities. After completing these analyses, the leader has alternative activity sequences to use with participants to satisfy individual objectives and the program objectives' criteria.

Leisure experiences are neutral until a value is ascribed by the "context." This context is composed of circumstances, expectations, norms, natural and controlled consequences, and nonspecific spontaneous interactions. A single activity may have a different value to each participant or, for the same participant, it may have different values at different times. Thus, the leader uses experiences (content) in a helping relationship (process) to achieve desired results.

The use of experiences to achieve participant outcomes is influenced by several factors. The participant's age at onset of disability and the abilities remaining influence the amount of previous exposure to recreative experiences and the potential to develop skills. The participant's capacity to receive feedback and to process and apply information enhances or detracts from the ability to perform. To illustrate, a person who is visually disabled yet who is physically capable of gymnastics may perform poorly because floor patterns and routines are not understood. The participant's perception of internal and external cues before, during, and after an activity affects performance. As an example, a person who is mentally retarded may continue to perform inadequately and with less skill than actually capable because audience clapping is perceived as positive reinforcement.

Value perceptions by self and significant others also weigh in program outcomes. A higher level of skill in swimming is valued and encouraged by parents if they have access to a backyard or a neighborhood pool. Success in table and board games is more highly valued when participants have siblings who are academic achievers. Lastly, the perspective of the participant and that of the leader influence the realized value of an experience. For instance, a participant may view participation as an "end unto itself" (fun) while a leader may intend the activity to be used as a tool to modify certain behaviors (therapeutic). A special education teacher may use the same experience to further the participant's education.

The process of activity analysis takes place when the leader studies an activity to establish the number, level, and types of behaviors (physical, cognitive, affective, and social) inherent in the activity. Each activity is broken down into each of the four behavior areas; then within each area, the various skills and their level of complexity are explored. A leader may initially complete this task on paper. As the leader becomes familiar with using the process it becomes less time consuming. The skills in each of the behavioral areas are presented in Exhibit 4-4.

Exhibit 4-4
THERAPEUTIC USE OF ACTIVITIES

Activity Analysis

The study of an activity to establish the number, level, and types of behaviors inherent in the activity with the purpose of selecting an activity to achieve specific outcomes.

Behaviors are present in four areas in every activity yet at any given time one is probably more evident or necessary to the completion of the activity than are behaviors from the other areas.

Cognitive

Intellectual behaviors are presented in a hierarchy from those requiring less to those requiring more skill.

Knowledge or recall of facts such as name and activity title.
Comprehension such as interpretation of scores or summarization of the leader's directions.
Application such as manipulation of figures to determine scores of others.
Analysis such as the breakdown of steps to complete a task.
Synthesis or design such as creating a picture or motor pattern from the leader's directions.

(Continued)

(Exhibit 4-4: Therapeutic Use of Activities--Continued)

Evaluation such as the decision-making or judgement to select one activity over another considering the influencing variables.

Questions the leader might ask to determine the cognitive requirements of an activity include:

Does the activity involve luck or chance?
How many steps and rules are involved in the activity?
What levels of math, reading, spelling, comprehension, memory, and recall are involved?
How much creativity is involved in the activity?
How much concentration is involved in the activity?

Affective

Emotional behaviors are also presented from the least to the most complicated.

Receive such as that demonstrated when listening or attending to music or someone talk.
Respond such as showing interest in or reacting to an activity that one likes.
Value such as showing appreciation or commitment to a particular leisure experience.
Organize such as that shown when one accepts the responsibility for behavior during an activity.
Characterize such as that demonstrated when one displays consistent behavior during an activity.

Questions the leader might ask to determine the affective requirements of an activity include:

Which emotions are openly expressed during the activity: joy, guilt, pain, anger, frustration, fear, and/or frustration?
Which of the above emotions must be hidden during an activity?
Does the activity provide for accomplishment and recognition leading to improved self-concept?
Is emotional stress created or relieved during the activity?
When and how frequently is emotional control needed during the activity?

Physical

The physical requirements of an activity include several behaviors that become more complicated as the participant is required to increase the speed, duration, and frequency with which the skill is displayed. Motor behaviors include balance, manipulation, coordination, sensation, gross, fine, and perceptual movements, body position, endurance, cardiovascular fitness, and fundamental skills such as standing, walking, grasping, throwing, rolling, bending, etc.

Questions the leader might ask to determine the physical requirements of an activity include:

What body parts are required during the activity?
What body positions are required during the activity?
Which of the senses are used during the activity?
What degree of range of motion, endurance, and fitness is required by the activity?
Are rest breaks built into the activity?
How much hand-eye or eye-foot coordination is used in the activity?

Social

The social behaviors in an activity become more complicated as more people participate in the experience. These behaviors are also influenced by communication, self-concept, the nature and timing of rewards, and the degree of structure given to the activity by the leader.

(Continued)

(Exhibit 4-4: Therapeutic Use of Activities--Continued)

The interaction patterns that may occur during an activity include:

Intra-individual occurs when one daydreams.

Extra-individual occurs when one plays cards.

Aggregate occurs when several people are each doing the same thing yet no one is interacting as in parallel play of children.

Inter-individual occurs as one person competes against another such as in playing cards.

Unilateral occurs when three or more people play against the person who is it as in King of the Mountain.

Multilateral occurs when three or more people are competitive yet no one is it as in poker.

Intra-group occurs when two or more people cooperate to accomplish a task like rowing a boat.

Inter-group occurs when two or more groups compete as in a sports contest.

Questions the leader might ask to determine the social requirements of an activity include:

How many people are required and in what interaction pattern will they participate?

What is the proximity of participants to one another and is physical contact required?

What degree of modeling is involved in the activity?

Are sharing, taking turns, and waiting required?

Which verbal and nonverbal communication skills are used?

Are etiquette and manners important to the activity?

Task Analysis

The study of an activity to identify the sequence from first to last of skills the participant must demonstrate to complete the whole activity with the purpose of presenting a step-by-step breakdown listing the skills from the initial or least difficult to the last or most difficult skill of the total experience.

Examples of task analysis are presented:

Objective: To throw and retrieve a horseshoe to a stake.

Sequence:
1. Grasp horseshoe
2. Hold horseshoe and swing arm
3. Release horseshoe toward target area
4. Walk toward target area
5. Pick up horseshoe
6. Walk back to starting mark.

Objective: To stop and start a cassette recorder.

Sequence:
1. Extend finger to play button.
2. Push play button down.
3. Extend finger to stop button.
4. Push stop button down.

Within the physical area, frequency, speed, and duration cause activities to be more or less difficult for the participant. Activities using fine motor and perceptual motor skills, such as molding clay and hopscotch, are more difficult than most gross motor behaviors, such as kicking a ball. When several fine motor skills, such as grasping-releasing, rotation, bending, and opposition, are required, the activity becomes more difficult than when one or two fundamental skills, such as throwing and catching, are involved. Bowling requires more fine motor skills than tossing a softball and is therefore more difficult. In an activity in which a number of skills from each physical area (gross, fine, and perceptual motor) are concurrently used, such as in riding an 18-speed bicycle, the activity is more difficult than one in which fewer skills are used, such as in catching a thrown ball.

The same analogy is made in each of the other three areas: knowledge is the least demanding cognitive skill; evaluation is the most complex. An activity such as remembering addresses or phone numbers of community leisure resources is therefore less difficult than the process of deciding which movie is the most beneficial. The affective skill of attending or listening to someone who is talking is less demanding than consistently demonstrating socially appropriate behavior. In the knowledge and affective areas, a skill hierarchy exists. When skills are used from each level along the continuum, the activity becomes more complex. Social skills, like physical skills, are not found as a hierarchy but are made more or less difficult by increasing the number of persons with whom the participant interacts. Thus, cooperating with one person is less complex than is competing as a team member. Social and physical skills are interactive. A participant who appears clumsy, awkward, or uncoordinated is stigmatized by the social expectations of others who perceive acceptance into a group to be influenced by one's presentation and mannerisms.

After each activity is studied to determine its skill components, a skill progression is developed. The process of designing this sequence is called task analysis (see Exhibit 4-4). A complete task analysis results in individualized sequences with skills listed from the first to the last skill in the sequence. These sequences help identify activity prerequisites, enable appropriate participant placements by comparison of participant functioning level to activity skill requirements, serve as measurement criteria to verify successful performance, and establish content presentation sequences.

Program objectives guide activity and task analyses. In the physical objective example (see Exhibit 4-3), each participant must visit two community-based leisure settings and report available services to the leader. In what activities would participants learn how to visit and gather information? Examples might include: collecting and reviewing brochures; listening to lectures by agency representatives; viewing commercials; listening to announcements; studying library resources; and having discussions with leaders and other leisure staff. The leader, after carefully studying each suggestion, would conclude that the least complex activity would be either agency representative lectures or leader discussions. A task analysis of either results in the following participant skill sequence: walking to the meeting area; sitting facing the presenter; watching the presenter; listening to the comments; looking at the presented resources; recognizing the leisure services of each; asking questions, if any; and upon demand, summarizing the listed services per agency. Each step in the sequence defines one skill that becomes a participant objective, the accumulation of which results in satisfying the physical objective.

For each written program objective, the leader completes both activity and task analyses. Content ideas generated during this process comprise programming options from which the leader may select when making up the activity schedule. Final program content is set after leadership needs are determined and management responsibilities assigned.

Process. This programming approach assumes that activities determine leadership methods and strategies or the program process. In the cognitive objective (see Exhibit 4-3), the conditions specify that, after completing at least three leisure awareness activities, the participant must identify three to five personal benefits of leisure. Therefore, a leader must plan activities requiring participants to consider leisure participation values. Through processes, such as observation of others, discussion about personal experiences, or with paper and pencil values clarification activities, participants become aware of their own personal leisure values. The leader selects a structure appropriate to these processes.

The structure of the experience is influenced by the setting, the leader's skills, the participant's functioning level, and community influences, such as transportation. Recreation activities may be structured as ongoing classes, drop-in activities, open gym-swim, competitive events, evening or weekend club or hobby groups, outings or field trips, extended day or school year programs, special events, and camping. When access to transportation is limited, field trips are not feasible. If participants' skills are not well developed, an open or drop-in activity would not be advisable. If the program is intended to have therapeutic results, specific educational classes or small-group skill programs, such as individual fitness, are appropriate.

Through assessments conducted during the needs assessment phase and when participants register, staff recommend programs suited to the participant's functional level. Referral and transition planning require community therapeutic recreators to place participants in programs compatible with out-patient goals. The presented program structure (therapeutic recreation, leisure education, and recreation participation) supports individualized placements by defining staff-participant leadership ratios. A participant may possess the activity skills to function on level three (recreation participation) but may lack the necessary community support skills, thus functioning at level two (leisure education). For instance, through a clinical rehabilitation program, a participant may have acquired skill in several table and board games but when playing among a group of people in a community center may become easily distracted and lack the concentration to successfully complete the experience. Conversely, a participant who has lived in a private community home may be capable of adjusting to integrated experiences but lacks the activity skills. In each instance, the appropriate participation structure should be employed with the participants.

It is the leader's responsibility to adapt to the participants' skill levels. The leader adapts recreational experiences in four ways: staff/participant relationship; behavioral demands of the experience; procedural or rule changes; and modification of the resources used to complete the activity (see Exhibit 4-5). For each general area of disabilities, specific leadership methods are recommended (see Exhibits 4-6, 4-7, and 4-8). The assumption is that more variability than similarity exists within each group and that each individual participant adapts in a personal way to life's demands, including recreation.

Exhibit 4-5
ADAPTING RECREATIONAL EXPERIENCES

1. Adjust the leader-participant relationship
    a. Modify the leader's communication and interaction methods
    b. Modify the degree of control by the leader
    c. Use various intervention processes, such as reality orientation
    d. Regroup participants
2. Alter the behavioral expectations of the experience
    a. Physical modifications
        Coordinate fewer body parts
        Reduce the number of items to be dealt with
        Reduce the speed of the task
    b. Cognitive modifications
        Simplify the organizational pattern
        Reduce the number of facts to be recalled
        Alter the number of steps involved to complete the project
        Select from fewer alternatives
    c. Affective-social behaviors
        Reduce the number of participants
        Increase the structure
        Modify the reward, intrinsic to extrinsic
        Allow more or less freedom of choice
3. Modify the procedures or rules
        Adjust the size or the space in which the activity occurs
        Alter the number of players or positions
        Allow more time or a greater number of actions
        Substitute actions
        Adjust the number of body parts used
        Alter distances
        Adjust the time allowed to score or win
        Permit assistants
        Develop new ways to do the activity
4. Modify the resources
    a. Supplies and equipment
        Modify the size and weight of materials
        Adjust the color of materials
        Alter the grip of rackets

(Continued)

(Exhibit 4-5: Adapting Recreational Experiences--Continued)

- b. Areas and facilities
    - Modify texture of surface
    - Adjust size of geographic area used
    - Decrease noise within the area
    - Assure accessibility
    - Control heat, light, electricity
- c. Supportive aspects
    - Adjust the number of staff and their assignments
    - Alter timing (daily, weekly) of experiences
    - Add rest intervals

Exhibit 4-6

RECREATION LEADERSHIP TECHNIQUES WITH PERSONS HAVING EMOTIONAL AND BEHAVIORAL NEEDS

1. Establish rules before the activity to provide structure necessary for participant to experience success. Give examples of "do's and don'ts" and consequences for behavior.

2. Identify safety precautions and participation requirements before the activity commences; e.g., wear gloves or use scissors in a certain manner.

3. Respond consistently, directly and firmly to participant's questions and behaviors; state your expectations precisely.

4. Be aware of your body language, voice tone and facial features, gestures and composure as participants "read" your responses and may be triggered by nonverbal communication.

5. Use touch and physical contact with discretion as participants may not comprehend the significance or meaning in physical distance. Some participants may fear closeness.

6. Plan activities to build on a social sequence so individual activities precede group activities and persons represent a variety of roles so participants identify and relate to authority figures.

7. Incorporate immediate extrinsic forms of reward working toward participants being motivated by "self" or internal satisfaction.

8. Participants may lack needed levels of energy (fitness), may tire easily due to medication, or may be easily distracted by extraneous environmental stimuli. Staff must be aware of extra noise, equipment, people, or other distractions in the activity area and the amount of endurance/strength required to perform tasks. Restlessness may result from already lowered energy levels.

9. Recreation activities strengthen weak defense mechanisms and provide an outlet for expression which serves to temper energy levels.

10. Participants may be tense and have a difficult time relaxing, thus, they are more likely to be hurt when they are hit or fall.

11. Satisfaction comes from things and activity, rather than words or observation; therefore, participants should be actively involved most of the time.

12. Participants must be assisted in making decisions and choices. They lack appropriate discrimination skills and the ability to set realistic priorities.

13. Complete newness may cause participants to be upset as they do not quickly adjust to change or make transition from one activity or person to another.

14. Recreation activities offer opportunities to practice social skills and remove barriers to appropriate leisure experience through development of positive self-concepts by participating in self reinforcing experiences.

Exhibit 4-7

RECREATION LEADERSHIP TECHNIQUES WITH PERSONS HAVING PHYSICAL DISABILITIES

1. Focus on participants' abilities; ask them first if assistance is required.

2. Develop a communication system, especially a way to identify basic needs and handle an emergency.

3. The age of onset of the disability and the degree of residual ability may determine the appropriateness of recreation activities.

4. Orient the participants to the program area; show them the location of the key features of the room or space.

5. The use of appliances and mobility aids requires a slower pace as they are heavy and may create balance and coordination problems.

6. Sudden or quick movements, dampness, temperature changes, and fine motor activities (arts and crafts) cause muscle contractures that limit range of motion and further restrict movement.

7. Consider the activity environment, such as the noise from a fan or the nature of the lighting; these may distract participants.

8. Participants may tire more easily due to the weight of the extra appliances or as a secondary effect of medication.

9. Artificial devices such as hearing aids or prosthetic limbs should be removed during activities so further damage to either the device or the user does not occur.

10. Study the physical accessibility of the area, including the support areas, bathrooms, parking lot, entrances and exits, telephone, and water fountains, to assure that they are usable.

11. The leader should be in a position where participants can see what is said and can observe other participants doing the activity so they can model or imitate the activity.

12. Include activities that strengthen muscles, increase breathing capacity, and improve posture.

13. Use the buddy system to allow participants to compensate for each others' functioning limitations.

14. Substitute players, skills, rules, equipment, or body parts/positions to compensate for limitations.

15. Decrease the space or increase the size of the area to allow participants to have more control over their activities.

16. Allow more variance in the program including rest periods, types of activities, time to complete the task, and desired outcomes.

17. Be aware of participant reflexes that are uncontrolled, the presence of pressure sores, seizure behavior, and the side effects of medication.

18. Swimming is one of the most useful activities as it does not require weight-bearing and allows a full range of motion in the joint muscles.

19. Before adapting an activity ask the following question: What will the change or alteration do to the quality of the experience for everyone involved?

Exhibit 4-8

RECREATION LEADERSHIP TECHNIQUES WITH PERSONS HAVING MENTAL DISABILITIES

1. Use physical guidance, demonstration, and manipulation with verbal cues and directions to develop a skill.
2. Focus on the skills performed and help the participants distinguish between their own "goodness" and their performance.
3. Participants cue off how something sounds rather than what is said; therefore the leader must be consistent, clear, and precise in voice tone and quality and in communication pattern.
4. Precede a direction with a participant's name, then give one- or two-step directions.
5. State health and safety rules first. Proceed with the activity giving verbal feedback and relying on imitation and modeling for participants to acquire activity skills.
6. A description must be precise. "Over there" is too general; "stand on the black line" is much more precise.
7. Introduce new skills early in the period. Participants learn by doing. Repeat the activity using a variety of techniques. Keep in mind that skill levels will not always improve with experience.
8. Structure the activity period to control the hyper and hypo activity level of participants.
9. Improvement in personal skills is more understandable than is competition for abstract goals among a group of participants.
10. Gross motor skills are acquired before fine motor skills.
11. Progress from the familiar to new experiences or the unknown.
12. Preparation before and follow-up after the activity are just as important as the activity itself; e.g., ADL activities and carry-over applications must be taught by participants doing.
13. Participants must be taught cause and effect relationships; e.g., what happens when the ball is kicked too hard.
14. The circle formation allows leader control and is a "natural" for modeling and imitation.
15. Set the parameters for participation before activity begins and consistently follow the established rules.
16. Plan for transition between activities; make an activity out of the time between scheduled activities; this prevents loss of time, energy, and participants.
17. Be patient. Break skills down to their fundamental parts; build from part to whole.
18. Use a few key words, frequently, to give directions; e.g., "Tommy, hold the ball with two hands like this, watch my hands."
19. Control the environment around the activity; e.g., eliminate people, noises, or excess equipment.
20. Keep personnel, activity areas, and schedules consistent; e.g., same staff with same activity on same time daily.

First, the leader uses various intervention processes with each different population group. Reality orientation is associated with aging persons and those having emotional impairments. Behavior management is employed with persons having mental and emotional deficits. Expressive media, such as dance, drama, and music, are suggested with autistic children. Aquatics is a frequently used program intervention with persons having physical disabilities. Outdoor adventure challenges are employed with youth and young adults exhibiting behavioral and emotional deficits. During programs, a leader may use specific forms of intervention drawn from a variety of approaches, such as assertiveness training, transactional analysis, gestalt, stress management, time management, and family therapy, to facilitate behavioral change without offering a specific class, such as resocialization.

A second way to adjust activities is to alter the behavioral requirements in the physical, social, cognitive, and affective areas. In the physical and social areas, a reduction in the number of body parts used or the number of persons involved in the activity makes an activity simpler. Choosing skills from the lower end of the hierarchy, such as recall and attending, in the place of those from the higher end, such as decision-making and role playing, will simplify activities in the cognitive and affective areas (see Exhibit 4-4).

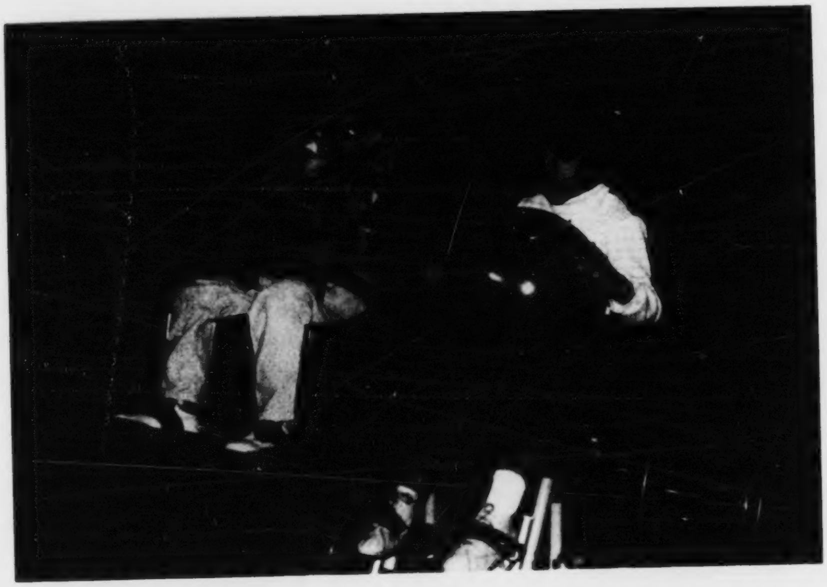
A third way a leader alters the activity is to make rule and procedural changes that allow the participant to succeed. For example, fewer points or a lower score may be required or participants may be assigned as buddies to help each other.

The fourth way to adjust an activity is to consider the resources used to complete the experience. Participants may find an experience more pleasing because the entry way and restrooms are accessible and close by. The leader organizes the equipment in a way that will not distract participants from the activity. The leader takes into consideration times of heavy and light traffic flow when scheduling activities.

The manner in which the leader intervenes is as significant as the program content. The leader as helper or facilitator brings to the therapeutic relationship one's own personal and professional beliefs. These beliefs are reflected in behaviors that influence the quality of the therapeutic interaction. Patience, active listening, empathy, commitment to participants, confrontation skills, concreteness, trust, warmth, genuineness, self-confidence, rapport, flexibility, energy, and unqualified acceptance of all participants are some of the essential helper qualities. These qualities are observed by others and the participants when the leader gives verbal encouragement, listens to the participant no matter how long it takes to complete a thought, or uses confrontation in a helpful manner with an indecisive participant. Exhibiting these subjective qualities is the key to truly being a therapeutic recreator.

A valuable feature of community-based programs is the use of volunteers. Volunteer time and contributions enhance program offerings, staff ideas, and administrator efforts. Selection, screening, placement, training, and supervision of volunteers are vital since volunteers represent the program and serve as "marketers" of program products. Facilitator qualities unique to therapeutic intervention are requisites for all team members, including volunteers. In this publication the word "personnel" refers to all persons who work with the department in any way, such as full-time, part-time, and seasonal staff; volunteers; recreation and therapeutic recreation college interns; hourly employees; and support staff, such as custodians, who may not directly service participants. Volunteers and interns submitting applications to be the "leaders" in therapeutic programs should be screened to determine the presence of the suggested "helper" qualities and supervised and evaluated

Walker is used to assist participant ambulation



Using balloons rather than rubber balls permits control and slower paced activity

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as "staff" who are expected to demonstrate the listed leadership skills. Sample contents of a volunteer manual are found in Appendix D.

Conclusion

Tasks completed during this planning phase are sequential with each being dependent on what has preceded and having an influence on what follows. For example, the nature of the philosophical statement determines the program structure. If the program structure is changed, then the philosophy statement must also be reconsidered. The purposes, goals, and objectives as presented describe "group" experiences or are appropriate with a department's therapeutic recreation program. The same tasks are completed to design programs with individual participants, presented in Part V, Implementation.

The information gathered during the assessment phase is taken into consideration as program outcomes are written into objective statements. These statements contain the information needed by a board or administrator to justify the outcomes of therapeutic recreation.

A well-defined program needs leaders with the proper dosage of "helper" skills to bring the program to life. The leader becomes a liaison between what's on paper and how beneficial the programming is to the individual participant.

SECTION B: MANAGEMENT PLAN

Introduction

The use of a management plan assures that the program is delivered as designed. The plan describes on paper the tasks to be coordinated by personnel, the resources needed to accomplish the tasks, and the sequences and time required to complete the tasks so as to enable continuous program operation.

A management plan serves as a marketing and accountability tool. The community, the agency, and the participants are provided information on needed resources, personnel responsibilities, expected target dates, and tasks necessary to implement programs. The manager uses the management plan to anticipate and to make personnel and fiscal decisions and to guide in the planning and implementation of programs. The plan is a formative evaluation instrument to assure that data are kept and adjustments are made in the ongoing planning and implementation of programs.

Management tasks outlined in this section are presented in more detail in the next part (IV) of this publication. The purpose of this section is to outline the critical management tasks and to introduce the importance of designing a management plan. Management plans are revised periodically to reflect time adjustments, altered personnel assignments, and resource modifications. Staff are better able to predict deadlines, income, expenditures, and resource usage with each new program cycle.

Plan Content

The initial step in preparation of a management plan is to list the tasks that need to be completed during each of the programming phases: assessment, planning, implementation, and evaluation (see Exhibit 4-9). The second step is to prepare a resource demand spread sheet (see Exhibit 4-10) on which the identified tasks are matched with the resources needed to complete them. There are likely to be limitations in the available resources, therefore trade-offs that make the best use of these resources will need to be made when assigning tasks to personnel and when deciding which programs are most needed.

Exhibit 4-9
MANAGEMENT PLAN TASKS

- Assessment
  - Identify assessment techniques and resources
  - Prepare assessment instruments
  - Organize advisory committee
  - Collect data from participants
  - Collect data from agency
  - Collect data from community
  - Analyze collected data
- Planning
  - Develop philosophy and program structure
  - Select program content
  - Identify leadership needs
  - Prepare management plan
  - Prepare participant and staff schedules
  - Prepare program resources
  - Develop operating policies and procedures
  - Develop risk management plan
  - Oversee budget functions
  - Prepare documentation and record keeping procedures
  - Develop staff training
  - Prepare marketing program
  - Develop evaluation plan
- Implementation
  - Conduct program registration
  - Complete individual participant assessments
  - Write individual participant plans
  - Conduct activities
  - Complete formative participant/program evaluations
  - Monitor budget functions and staffing
  - Conduct staff supervision and development
  - Inspect and document health/safety and participant involvement
  - Monitor and communicate with market audiences
  - Adjust programs and services

(Continued)

(Exhibit 4-9: Management Plan Tasks)

Evaluation
- Conduct summative evaluations on participants/programs
- Analyze collected data
- Update participant files
- Update documentation and record keeping procedures
- Adjust budget, staff, programs, and services
- Revise risk management, marketing, and staff training programs
- Prepare transition information
- Prepare final program report
- Present report to Advisory Committee

Managers may elect to use flow charts, networks, or calendars to plot interrelationships between tasks, time, personnel, and resources. These may appear as bar graphs or PERT (program evaluation review technique) charts. These models give order or sequence to the manager's task list. However, they must be viewed as fluid or dynamic tools which the manager adapts to accommodate for changes in the budget, staffing patterns, or availability of resources. These charts also assist the manager to prepare for one program while implementing another.

Management Tasks

Developing a program schedule and calendar consumes large amounts of a manager's time. To assure continuity and balance the manager first designs a yearly schedule, then breaks it down further by season, week, and finally, day. Facilities or areas, personnel, and time slots are assigned to programs and services.

The individual participant's schedule is determined either at the time of registration or when the participant is placed in programs by staff. In the first option the participant's activities are actually predetermined since the participant is registered according to either functional level or disability category. In the second option the staff places the participant in programs that are recommended in transition or referral plans, academic IEPs or IPPs, or as the result of individualized staff assessment. Both of these options may be affected by the availability of transportation; a participant's schedule may require adjustment to accommodate for available public, private, and/or family transportation.

Staff schedules and assignments are finalized following development of participant activity schedules. When determining staff hours, consideration must be given to the following factors: when the activities are offered; balancing staff days off and on; rotating day, night, and weekend duty; designating persons in charge; maintenance and cleaning schedules; coverage for staff absenteeism; staff-participant ratios; pre- and post-session evaluation; agency personnel policies affecting compensation, seniority, work hours, and staff responsibilities; and allotting time for support duties, such as recordkeeping, housekeeping, staff meetings, and training needs.

Exhibit 4-10

Resource Demand Spread Sheet

		FACILITIES (AREAS SUPPLIES EQUIPMENT)										TIME					BUDGET		
TASK	STAFF (no., skills)											HOURS	DAYS	WEEKS	MONTHS	# OF STAFF X (HRS X DYS X WKS X MOS)	INDIRECT COST (estimate)	DIRECT COST (estimate)	TOTAL (Approximate)

A second management task is to purchase, replace, repair, and organize materials, equipment, and supplies. Inventories, use demands, capital expenditures, and monitoring policies on the use of vendors, donations, contributions, and shipping and handling are entailed in this ongoing task. The inventory process requires personnel time to update records, account for major items, and document the condition of programming resources. Procedures to follow to acquire new supplies, replace old, repair broken items, and accept donations must be outlined. A plan for long- and short-term capital purchases must also be defined. Alternative materials and resources must be either identified or prepared. Written policies on equipment use and safety must be developed.

Budgeting is an ongoing management task. As the budget is prepared and placed into operation, staff and resource monitoring occurs. Records must be maintained of income and expenditures for each program or service. A good manager is able to deliver cost-effective programs and services having therapeutic outcomes. Budgeting and program development go hand in hand. A budget narrative describes how agency services intend to accomplish the stated objectives (see Exhibit 4-11). During the budget process, these objectives are prioritized (weighted) and programs are designed to ensure accomplishment of the weighted objectives. Weighting serves a two-fold purpose: monies are allocated for the prioritized programs and, if further budget adjustments are necessary, decisions must be made to delete programs near the bottom of the prioritized list.

Two of the budgetary processes used in the public sector are incremental and zero-based budgeting. An incremental budget process requires the manager to reassess the whole budget in light of a given percentage increase or decrease. The manager monitoring a zero-based budget must justify or defend each account (service) as the next year's budget is planned. The budget development timeline is influenced by the fiscal year (FY), which may or may not coincide with the program calendar year. The FY may run from January 1-December 31, October 1-September 30, or July 1-June 30. Programs are offered in the fall, winter, spring, and summer to correspond to the school year and/or holiday calendar. The manager simultaneously projects future income and expenditures while monitoring the current fiscal year's budget and, in some instances, readjusting allocations in the current budget. Budget preparation requires the manager to develop defensible, measurable budgets for each program or service. Each budget and appropriate justifications are presented through the chain of command to the appropriate administrative staff and then to the board (council) for final approval as the current fiscal year nears the end.

Routine monitoring tasks include recording and reporting: 1) cash flow from fees and charges, donations, and special projects; 2) expenditures for personnel, supplies, and equipment; and 3) overhead or indirect costs, such as utilities and office supplies. Protocol establishes due dates, forms used, and priorities assigned during budget preparation and operation. An often recommended approach is to project income conservatively and expenses liberally, remembering that expenses are more predictable than is income and that adjusting upward is more comfortable than is cutting back.

PROGRAM OBJECTIVES - FORM 1-A

DEPT./DIV. Recreation/Community Activities **PROG.** Therapeutics

PROG PRI	OBJECTIVES	PERFORMANCE CRITERIA:	19__ UNITS	19__ BASE UNITS	19__ DISC. UNITS		19__ DISCRETIONARY			CITY MANAGER DISCRETIONARY RECOMMENDATION
							DISCERTIONARY	Position Impact		
					Dept Disc Unit			POS.	FILL	
1	To operate a total of ninety (90) recreation/ leisure programs for Special Populations, ages 5 and older in recreation facilities throughout the city.	To implement 90 recreation/ leisure programs which would operate between 3 and 10 hours per week for 10 weeks.	90	70	10	20	15,000 P 4,500 F 19,500	*	*	
		To implement 10 recreation/ leisure programs which operate between 28 and 33 hours per week for 8 weeks.	1,920	1,520		400				
		To maintain individual participation in recreation programs for disabled.	19,083	15,263		3,820				
2	To administer all Therapeutic Recreation service delivery in 19__.	To maintain total participation in 90 recreation programs offered in 19__.	6,466	5,176		1,290				
		Use of volunteer hours.	N/A							
		To supervise 3 full-time and 55 part-time program staff in 19__.								
		To supervise 1 clerical staff who will provide all clerical assistance.								

*Reduction in the authorized hours of part-time positions. No positions eliminated. Also, fringe amount is significiantly overstated since actual amount required is less than 4%

Development and organization of records and reports is a management task undertaken when a program, single activity, or special event is planned. Records provide evaluation data, depict the scope of service, and document the use of resources. Types of records to be prepared and kept during or following a program include: 1) administrative, such as insurance and risk management forms; 2) program, such as attendance records, program plans, and registration forms; 3) personnel, such as evaluation and medical forms; 4) finance, such as petty cash, requisition, and purchase order forms; and 5) documents used with buildings, areas, and program resources, such as safety checklists and inventory forms. A system of filing records and reporting service operation must be set up. Written policies should note who uses which form to report what, where the completed documents are to be kept, and when reports are due and to whom. A manager must make sure adequate copies of all forms are ready when needed by the staff.

Transportation issues vary from one community to another. An agency's policy may prohibit the provision of participant transportation between residences and program sites yet allow the transporting of participants during program operation. Cooperative use agreements with peer agencies may enable field trips, tours, and special outings. The manager must be assured that staff possess proper credentials, such as defensive driving, first aid, CPR, and a chauffeur's license if required by state law. Contingency (alternate) plans must be developed in case of unexpected events, such as if vehicles are not available at the auto pool due to needing unscheduled repairs. Emergency plans must be designed, such as procedures to follow when a vehicle breaks down during an outing.

Safety is the essence of quality assurance and risk management. Whether a swim program with youth having orthopedic disabilities or a walking activity with seniors is being offered, precautions to assure a safe experience are the responsibility of the professional staff. This requires the design of a risk management plan which may include preparation of a plan of supervision, completion of a safety checklist prior to the activity, filing quality assurance reports, and inspecting a building or area as it is locked up. Conducting inservices on emergency and disaster plans and routinely holding fire and emergency drills encourages safety awareness among staff and participants.

Without marketing, programs and services go unnoticed. This management task requires planned, ongoing information dissemination to administrators, staff, family members, peer agencies, the public at-large, and special audiences, such as advisory committee members, physicians who refer participants, special education teachers, social workers, and vocational rehabilitation personnel. Each program, activity, or event should receive some form of publicity. Bulletin boards, brochures, and PSAs (public service announcements) require adequate preparation time and lead-time as does the publicity after an activity.

Other critical management tasks are the scheduling of staff training and the implementation of an evaluation plan. Staff must be prepared to deliver services and the tools must be in place to conduct evaluation at designated intervals. The scope of the event will determine the amount of time devoted to staff training. For instance, summer day camp requires more indepth preparation than does a one-day field event. Yet, for both, staff require direction. Staff must also be prepared to evaluate and be evaluated. Thus, the evaluation schedule and the revision process are established. The evaluation forms and the staff are prepared to collect the necessary data.

Conclusion

A management plan is a tool summarizing the tasks to be completed in order to enable service delivery. A model combining narrative with graphics depicts the tasks to be completed, the timing of the tasks, the relationships to each other, and in some instances, who completes the tasks, what resources are needed, and what are the costs. A master plan or long-range plan is a management plan. Likewise, a planning model for a particular event is a management plan (see Exhibit 4-12).

Exhibit 4-12

PLANNING MODEL

This information is intended to guide the preparation and delivery of programs including ongoing activities and special events. The organization of materials and reports may occur using the listed categories. This allows continuity and uniformity in services while preventing duplication as events are conducted by different staff members.

Preliminary Consideration

- Program objective and relationship to department and community
- Assessment of need with regard to community, department, and participants
- Participant objectives compatible with program objectives of department
- Budget - projected income, expenses, in-kind from department, cooperative sources, cost analysis with regard to department programs
- Department protocol
- Other

Preplanning

- Dates and timing
    1. Relationship to master calendar and other related events
    2. Facilities and equipment and staff available with alternatives
    3. Relationship to routine program, e.g., culminating and unifying event
    4. Pacing between special events
- Develop time schedule and assign committees
    1. Steering
    2. Program
    3. Publicity/promotion
    4. Decoration
    5. Refreshment and concessions
    6. Clean-up/set-up

(Continued)

(Exhibit 4-12: Planning Model--Continued)

7. Awards/prizes
8. Finance
9. Judges and officials
10. Physical arrangements/travel/accommodations
11. Resources/supplies/equipment/facilities

Develop staff training
Sign cooperative agreements
Submit proposal to proper authorities
Determine evaluation process and criteria
Develop registration/waver forms
Establish rules of conduct/entrance criteria
Determine audience
Identify interested publics

Planning

Formulate participant/program objectives
Secure staff and train (volunteers too)
Secure facility and equipment, sign agreements
Schedule events and assign staff including maintenance
Assure participant accommodations and travel
Make media contacts
Design alternative plans
Check insurance, first aid, emergency, safety procedures
Develop documentation process and procedures
Obtain committee progress reports and assess time schedule
Prepare finances

1. Source of funds
2. Itemized budget
3. Cost analysis
4. Fees and charges

Prepare program evaluation plan
Identify participant precautions
Make adaptations in leadership, resources
Order awards and establish performance criteria and award procedure
Maintain "Thank you" list
Check parking and transportation and equipment condition
Assure accessibility of site, accommodations, travel
Computerize forms, records, reports
Order food - refreshments and concessions
Assure participant requirements - foods, clothing, money, releases, emergency process
Registration process
Other

Implement the Event

Assign "runners"
Check set-up
Obtain releases
Cash on hand

(Continued)

(Exhibit 4-12: Planning Model--Continued)

- Medical/safety coverage
- Maintenance
- Phone list
- Staff schedule and alternative timing/staff
- Complete process evaluation and adjust program
- Re-check participants' needs (accommodations, travel, adaptations, skill level, releases)
- Recheck cooperative agreements and personnel
- Maintain budget
- Assure proper identification of all participants and representatives
- Recheck media
- Supply and serve refreshments/concessions

Evaluate Event

- Complete summative evaluation
    1. Collect committee reports
    2. Finalize budget
    3. Collect participant, staff, agency evaluations
    4. Analyze data
- Develop report and present to department and cooperative agencies
- Revise program based on recommendations
- Determine future needs
    1. Participant requests
    2. Leader/resource persons
    3. Budget
    4. Supplies/equipment/facilities
    5. Physical arrangements
    6. Public relations
    7. Progress toward participant and program objectives

Follow-up

- Facility cleaned up
- Supplies and equipment returned
- Public relations materials filed
- Bills paid
- Thank yous extended
- Evaluations and reports computerized in central file

Summary

The two planning tasks presented in this portion of the text are primarily paper-and-pencil activities critical to justify a program's existence and assure effective program delivery. From the assessment data collected, the staff makes decisions about program structure (such as integrated and segregated or centralized and decentralized) and focus (such as therapeutic recreation, leisure education, or recreation participation). After these decisions are made, staff write purpose, goals, and objectives for each program component. These statements become the basis for writing program (aquatics for example) and individual participant objectives. Objectives give direction to the nature of program content and evaluation which guide staff selection of leadership processes.

A management plan details all tasks completed prior to, during, and following a program cycle of assessment, planning, implementation, and evaluation. The plan may appear as a monthly "To Do List" or a specific event "To Do List." Charts and graphs reflect the ongoing nature of managing programs. As one program is implemented, the budget justifications for the coming year are being prepared with data gathered from past programs to support the coming year's requests. Staff participation in the development of a management plan may assist them to appreciate their efficient use of program downtime.

KEY TERMS

Activity analysis. A process used to determine the types and number of cognitive, affective, social, and sensory motor skills required to successfully participate in a recreative experience.

Contingency plan. A plan of action prepared as an alternative to an original course of action. This alternate or additional resource is used when an element of risk interferes with the original plan.

Functional ability (levels). A participant's cognitive, affective, sensory-motor, and social capabilities with reference to the degree(s) of successful performance in relevant situations.

Individualized objectives. Statements describing in measurable terms what each participant will be capable of doing following participation in a program.

Outdoor adventure challenges. Programs in which a series of obstacles must be negotiated and/or problems solved to complete the experience. They are used to enhance decision-making, social interaction, and self-esteem.

Program objectives. Statements describing measurable outcomes for a specific program, such as a leisure education class.

Quality assurance. A process which enables staff to identify areas needing improvement and potential problems in order to design a plan to assure that participants' objectives are met.

Task analysis. A process used in concert with activity analysis to design skill sequences or progressions by the number of skills present in each activity.

Time management. A technique used to enable participants to analyze how they spend time so they are better able to set priorities, establish goals, and assign time to tasks in order to gain a feeling of accomplishment.

TRAINING EXPERIENCE AND STUDY QUESTIONS

1. Review the steps given in Section A to design a therapeutic recreation program. What are the pros and cons of using a systematic approach to design therapeutic recreation programs?

2. Collect samples of participant program plans from special education teachers and vocational rehabilitation counselors. How are these documents similar to or different from the sample model in Section A?

3. Review the activity analysis and the task analysis processes given in Section A. Select a common activity with which you are familiar, such as bouncing a ball, and complete both an activity analysis and a task analysis.

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PART IV

PROGRAM OPERATION

INTRODUCTION

This portion of the text contains information on the broad tasks undertaken during the planning phase of program design. The four encompassing tasks, writing policies and procedures, preparing a risk management plan, designing a staff training and development program, and preparing to market and communicate as a helper in therapeutic recreation, are indicators of the quality and availability of the programs and personnel.

Operating policies and procedures set the parameters for participant and staff decisions and behavior and govern management functions and program operation. A risk management plan is a document and a philosophy which attempts to assure safety and define a course of action to prevent actions which could become harmful. Staff training and development programs are twofold: one intent is to assure that staff have the necessary skills to function in their day-to-day job tasks; a second intent is to assure that staff continue to develop skills which foster their personal/professional growth as therapeutic recreators. Marketing therapeutic recreation services includes consideration of the audiences and avenues to whom staff must communicate. Effective communication assures accuracy and accountability among participants, staff, funding sources, decision-makers, and caregivers. The true test of the quality with which these four tasks are completed comes during program implementation. The participant numbers in attendance are a reflection of marketing and communication. Program quality is a reflection of staff competence. The safety with which a program operates is defined in a risk management plan. Enforcement of written operating codes also occurs during program implementation.

SECTION A: OPERATING POLICIES AND PROCEDURES

Introduction

Policies and procedures are written codes of conduct or guidelines that staff must adhere to as services are delivered. They serve as standards to assure quality service delivery. It is common practice to assemble a manual which contains all policies governing administration, personnel, programs, participants, and physical resources. Also included in the manual are samples of the forms and operational documents which are required to be used. A policy manual is presented upon employment and is used during staff training and as the program is managed. Contents of the manual come from agency operation codes, legislation and laws governing personnel and programs, state and local ordinances, and professional documents and literature, such as professional standards of practice.

A section of the manual or a separate manual may be prepared to specifically deal with therapeutic recreation services. All staff members should have a personal copy or at least a copy of those sections pertaining to their performance. Organization of the manual is improved if it is color- coded or indexed to correspond to program areas, such as creative arts or summer program, or to topics, such as administration or participants.

Administration

The section entitled "administration" contains the guidelines influencing overall service operation. These guidelines include an organizational chart, the agency's philosophy statement, goals, and objectives, and a definition of the agency's program structure (see Exhibit 5-1). This section may also contain the charter and bylaws and board policies. Specific policies may be included pertaining to office procedures, such as telephone usage,

Exhibit 5-1

OPERATING POLICIES AND PROCEDURES—ADMINISTRATION

Subject: GOALS OF THE RECREATION COMMISSION

The overall goal of the Recreation Commission is to provide effective leadership, adequate facilities, and wise planning and financing for recreation, so that all residents will have the opportunity to enrich their lives through meaningful leisure time activity.

Through its programs the Commission will endeavor to:

1. Teach skills and provide knowledge and stimulate interests which will make possible worthwhile leisure time activity.
2. Provide new challenging recreation experiences consistent with the interests, needs, and abilities of all citizens regardless of age, sex, race, creed and economic status.
3. Provide an opportunity for individual creativeness, self-expression and self-fulfillment, and an appreciation of beauty.
4. Develop qualities of leadership and good citizenship.
5. Provide opportunities for individuals to satisfy their social needs and develop well balanced personalities.
6. Help individuals attain good mental and physical health.
7. Provide adequate facilities for family recreation.
8. Promote an understanding and appreciation of democratic principles and a respect of country.

Furthermore, in the interest of providing the best possible recreation program for all the residents, the Recreation Commission pledges itself to cooperate with all agencies, private and public, and in all practical ways to encourage and welcome advice and opinions from participants and the interested public.

use of copy machines, mail, word processing, keys, information board, emergency procedures, typing requests, policies on posting of printed materials, and the participant transportation log (documentation of who is permitted to drop off and pick up each participant). Procedures for communicating within the agency and to the public need to be established to assure good public relations. This section includes policy statements pertaining to staff meetings, interagency cooperative agreements, user policies, and information dissemination to participants and caregivers. The administrative section of the manual is also the appropriate location for general statements regarding compliance with federal, state, and local ordinances. Civil rights compliance, accessibility, and requirements of Section 504 of the 1973 Vocational Rehabilitation Amendments Act are examples of such ordinances. A listing of agency committees and their respective functions and membership are important to present to full-time staff. The procedure used to prepare, adopt, and modify policies and procedures might also be stated.

Personnel

Agencies may have formal personnel guidelines developed by a personnel manager or division. Agencies with fewer full-time therapeutic staff but with many seasonal personnel and volunteers may prepare a document specific to therapeutic personnel. Standard content of personnel manuals includes: hiring and termination procedures; probation, evaluation, promotion, disciplinary actions, and grievance procedures; work hours, compensation, benefits, vacation, leaves, and absences; vehicle use; and rules of conduct. Some specify employee relations with supervisors and the public by stating policies on gifts, solicitation of funds, publicity releases, supervisory requests, and use of the facilities by staff after working hours.

Personnel policies generally specify standards bearing directly on service delivery, such as punctuality, use of chemical substances, smoking, care of equipment, on-the-job safety, quality of work, appropriate dress, identification (staff IDs), illness or accidents, residency, record-keeping, work behaviors, staff substitute list, tips or gratuities, time off, health examinations, confidentiality and ethical standards of professional conduct, staff medication, and use of specific client intervention techniques, such as behavior management (see Exhibit 5-2). Also included are specific job descriptions, individual performance objectives, evaluative criteria, and samples of the forms to be used when requesting, for instance, vacation, mileage, petty cash reimbursement, pay advances, and holiday and personal leave, or for reporting accidents and injuries.

Volunteer and student intern policies may either be placed in the section of the manual pertaining to "therapeutic personnel" or they may be contained in a separate document. A copy of these policies should be given to each new volunteer and student intern. Policies to acquaint these persons with during orientation or in-service training include: selection, training, and supervision procedures; conduct and behavioral rules; chain of command; participant management policies; ethical, legal, medical, safety, and professional codes; program philosophy; and the role and responsibility of personnel as representatives of the agency in the community (see Appendix D).

Exhibit 5-2

OPERATING POLICIES AND PROCEDURES—PERSONNEL

PERFORMANCE GUIDELINES:
Conditions of Employment and Disciplinary Actions

The following conditions of employment are to be adhered to by all employees of the Division of Therapeutic Recreation. Failure to abide by these conditions will result in the indicated disciplinary action. Please review each condition carefully and sign the "receipt of performance guidelines" form.

This form will be kept in your personnel file. If you have any questions concerning these conditions, please ask your immediate supervisor.

1. Punctuality
   You are expected to be at your work site at the designated time, one half hour before program delivery unless changed by your director or coordinator. If you cannot arrive on time, you must call the main office, or your coordinator/supervisor at home and notify them of this fact.
   First Offense - written reprimand
   Second Offense - pay docked and/or written reprimand
   Third Offense - pay docked and/or termination at discretion of supervisor

2. Absence
   If you cannot arrive for work at all that day you must call your coordinator or supervisor prior to your absence and explain why. There is no excuse for an unexcused absence. A doctor's statement can be requested for continual absence due to illness. The procedure applies for staff meetings as well.
   First Offense - written reprimand and/or termination at discretion of supervisor

3. Use of Alcohol or Chemicals
   At no time shall you report to work under the influence of a drug (alcohol, marijuana, amphetamines, etc.). Consumption of alcoholic beverages or other chemicals is prohibited on program sites. Staff who are under the influence of alcohol or drugs during program hours will be dismissed immediately.

   First Offense - written reprimand, 5 working day suspension or termination
   Second Offense - Termination

4. On The Job Safety
   At all times, you are expected to carry out your duties in a manner that will allow the least possibility of danger or injury to yourself, the participants, or others. All employees must

(Continued)

(Exhibit 5-2: Operating Policies and Procedures--Personnel--Continued)

adhere to all posted safety rules and regulations of the facility you are in. Failure to adhere to or recognize safety requirements will result in the following:

First Offense - written reprimand
Second Offense - reprimand, 5 working day suspension
Third Offense - reprimand, suspension and/or termination at supervisor's discretion

5. Care/Use of Equipment

At all times, you are to exercise the utmost care in the use, storage, and transport of Therapeutic Recreation equipment and supplies. If an equipment item is found defective in any way, you are to report it immediately to your director/coordinator.

First Offense - written reprimand
Second Offense - reprimand, payment of cost of replacement
Third Offense - reprimand, payment of cost for replacement, and/or termination at the discretion of the supervisor

6. Dress

At all times, you are to be dressed appropriately for the activities. You are also expected to be neat and orderly in appearance as a representative of the Division. Modest clothing, one piece swim suits, and gym shoes are required. No halter tops, tube tops, or sandals are permitted. All staff must wear name tags during program hours, which should be displayed on the upper left side of the staff shirt.

For Fall, Winter, Spring programs, staff shirts or Division Logo shirts should be worn regularly (not swim programs). For Summer programs, staff shirts should be worn twice per week. For field trips all staff should wear staff shirts if appropriate.

First Offense - verbal warning (noted in file)
Second Offense - pay docked and/or go home to dress appropriately
Third Offense - same as second or termination at discretion of supervisor

7. Quality of Work

At all times you are expected to perform your job to the utmost of your capabilities. Discourteous behavior to the participants, parents, or other staff will not be tolerated. Failure to meet specific assignments from your supervisor will result in disciplinary action.

First Offense - action at supervisor's discretion based on severity of offense

8. Confidentiality

As an employee of the Division of Therapeutic Recreation, you must maintain in confidence all information relating to a participant or situation relating to a participant. Specifically you must not discuss any information pertaining to a participant with anyone other than the appropriate individuals (i.e., staff, parents, program coordinator, supervisor).

First Offense - written reprimand
Second Offense - reprimand, 5 working day suspension
Third Offense - reprimand, suspension and/or termination at supervisor's discretion

(Continued)

(Exhibit 5-2: Operating Policies and Procedures--Personnel--Continued)

9. Submittal of Reports, Schedules
Program director and assistant directors will have periodic paper work assignments and submittal dates. Failure to submit paperwork requirements (statistical data, participant assessments and evaluation, program and individual goals, time sheets) by the due date, without previously requesting an extension, will result in the following:
First Offense - verbal warning (noted in file)
Second Offense - written reprimand
Third Offense - reprimand and/or termination at supervisor's discretion

10. Allocated Hours
For each program, a specific length of time has been established as program allocation. This time is based on actual program time, preparation, evaluation, clean-up, and paperwork time. No staff member will be paid for hours submitted over the allocated number unless the additional time needed is approved by the supervisor 5 days in advance of the additional work.
First Offense - verbal warning (noted in file)
Second Offense - written reprimand
Third Offense - reprimand and/or termination at supervisor's discretion

11. Staff Ratio (directors only)
At all times you are expected to monitor the staff-to-participant ratio of your program. If the attendance is significantly lower than average and the program could be conducted with fewer staff, the program director is required to send assistant(s) home. If it is a summer day camp program, the director must check with the coordinator to see if additional staff are needed at another program. If the decision to send staff home is questionable, call your coordinator or the Division's supervisor.
First Offense - verbal warning (noted in file)
Second Offense - written reprimand
Third Offense - reprimand and/or termination at supervisor's discretion

Programs and Resources

General program policies are developed about the following: the program calendar or year; guidelines for field trips and special outings; types of fees and charges; populations served; registration, enrollment, cancellation, and program changes; communication and correspondence on programs with caregivers and the media; fundraising; visitors and guests during program hours; and special precautions or emergencies associated with programs, such as transportation or building use procedures. Regulations about the use of areas, facilities, and equipment may be necessary to assure compliance with safety standards and budgetary restrictions or procedures (see Exhibit 5-3). Policies on clean-up, locking or securing the building or equipment, storage and condition of equipment, opening and closing procedures, use of each inside and outside activity area, and samples of the forms to use when requesting repairs, purchases, rentals, or maintenance are incorporated in this section of the manual.

Participants

This section of the manual will be more unique to therapeutic services than previous sections. This is justified by the additional "helper role" performed by staff, a role not usually as vital to other leisure service areas. The primary and secondary disabilities of participants may limit their decision-making skills and their ability to initiate some actions. Consequently, policies on participant health and safety are included (see Exhibit 5-4). Specific procedures may be written in the following areas: participant attendance; lost participants; medications; emergencies; discipline; sexuality; socialization; participant information files and classification system; abuse and neglect; transportation; medical information, such as on atlantoaxial dislocation, hepatitis, and social diseases; research with participants; staff contact with legal guardians; participant transition and referral; and ethical concerns, such as confidentiality, privacy, and fraternizing with participants. Also included in this section of the manual may be samples of the forms to be used for registration, assessment, and evaluation and those to be used to record information about individual participants.

Conclusion

Policies govern actions and are therefore as critical to the program as is the content and the leadership. Policies give direction to decision-making and set standards regulating safety, professional service delivery, public involvement, and participant outcomes. For example, pertinent policies are printed on participant registration forms. Staff/participant ratios are determined from the interpretation of the agency's philosophical statement. Policies establish the types of cooperative agreements which may be made with other community agencies. Policies are modified continuously as the needs of constituents are met through creative management.

Objective, consistent policy interpretation is essential to the management of quality services. Each person associated with the therapeutic programs must implement the stated policies in the same manner. Staff training emphasizes not only "what" each staff member is to do during a program but "how" the program is to be delivered. Adherence to written policies enhances the public's confidence and encourages professional programming.

Exhibit 5-3

OPERATING POLICIES AND PROCEDURES—PROGRAMS AND RESOURCES

USE OF PROGRAM FUNDS

Program fees are assessed to all Therapeutic Recreation programs according to the length and type of program. In addition a yearly membership card is required for participation in most T.R. programs.

A percentage of the program fees collected is available for use for that specific program. Items such as snacks, craft items, or specialized equipment that are not available through departmental stores may be purchased with the approval of the program coordinator.

The agency has established purchasing contracts with a variety of local vendors so that materials and supplies can be obtained without exchanging money. Prior to purchasing any item for program, all staff must check with the program coordinator to see if the item is available at one of the contracted vendors. Any staff person purchasing items without checking with program coordinator will not be reimbursed for their purchase.

When making a purchase for program, staff are required to use the tax exempt number. Employees failing to use the tax exempt number will not be reimbursed for the tax amount.

Fundraising events may be conducted by T.R. programs if approved by the T.R. supervisor at least seven days in advance of the event. Fundraising events should be held only to raise money for specific outings that otherwise would not be affordable.

A fundraising event should be one that can be participated in by all participants, or another simultaneous activity should be conducted for those unable to assist with the fundraiser.

All fundraising monies must be submitted to the program coordinator within three days of the event.

REFUND POLICY

As previously mentioned, program fees are assessed to each Therapeutic Recreation program. Program fees may be refunded for the following reasons.

a) Program cancelled by the Division due to insufficient enrollment (less than 10 persons).
b) Medical reasons causing the participant to be unable to begin or continue the program. A physician's note may be requested to confirm.

In the event participant has attended program prior to requesting refund for medical reasons, a pro-rated portion of the program fee will be refunded.

Membership card charges are not refundable.

(Continued)

(Exhibit 5-3: Operating Policies and Procedures--Programs and Resources--Continued)

SCHOLARSHIP INFORMATION

The Division of Therapeutic Recreation Advisory Council has limited funds available for scholarships. These funds are used to supplement program fees so that all program participants will have the opportunity to participate in therapeutic recreation programs. Scholarship assistance is determined by ability to pay and need. All scholarship applicants must reapply for assistance prior to each 10 week program season.

Please use the following scale as your guideline for determining how much scholarship assistance you will need. The Division realizes that needs may vary according to your family size and individual circumstances. If you would like the Division to assist you in determining the program fee you should pay according to this scale, please call for assistance.

Approximate Yearly Gross Income	Amount of Scholarship Assistance
under $8,000	100%
$8,000 - $10,000	90%
$10,000 - $12,000	80%
$12,000 - $16,000	60%
$16,000 - $20,000	40%

Detach here

SCHOLARSHIP APPLICATION

Please fill out the information below and return this application as soon as possible to the Division of Therapeutic Recreation.

Name of Participant ____________________

Address ____________________ Zip ________ Phone ________

School ____________________ Teacher ____________________

Program ____________ Season ____________

A. 10 week program fee: ________

B. Amount of fee participant is able to pay ________

C. Amount of Scholarship requested (subtract B from A) ________

____________________ ____________

Signature of Parent or Guardian Date

Exhibit 5-4

OPERATING POLICIES AND PROCEDURES—PARTICIPANTS

PARTICIPANTS WITH UNMANAGEABLE BEHAVIOR

It is the policy of the Division that participants with behavior problems will be disciplined at program. Staff will be periodically instructed in behavior management techniques and should seek additional training if they feel inadequate.

If a participant becomes very unruly and/or unmanageable the coordinator should be notified as soon as possible. If the coordinator determines that the participant's behavior is unmanageable, the participant should be sent home.

If the coordinator or supervisor are unreachable and the director feels that the participant's behavior is potentially harmful to staff or other participants, then the participant should be sent home.

If parents/group home staff are not home or do not come in a reasonable amount of time, the director may contact the police to take the participant home or to the hospital.

PROCEDURES FOR DISCIPLINING PARTICIPANTS

As previously mentioned, participants who misbehave at program should be immediately disciplined.

Ignoring inappropriate behavior can be effective but is not the approach if the participant is disrupting the entire activity or causing a potential safety concern.

The following guidelines should be followed for managing behavior problems and disciplining participants:

1. Take preventive measures to help avoid discipline problems. Structure the day to minimize down time or delay between activities. Plan for a smooth flow from one activity to the next.
2. Structure the activities so that everyone participates in an organized manner. Allow a reasonable amount of freedom within activities (within safety limits). Give participants sufficient space for freedom of movement. Emphasize the fun element, minimize restricting rules if not safety related.
3. Watch for potential problems and change the existing situation before it becomes a major problem. Divert participant's attention to something else. Change participant grouping. Substitute something acceptable for the unacceptable.
4. Plan for successful participation to minimize frustration. Avoid win-lose situations. Try cooperative group activities.
5. Use the positive rather than the negative. Make positive statements about what the participants should do or are doing well. Negative statements do not tell a participant what to do.
6. Be consistent in what you say and do. Don't make empty threats. Be specific and simple in stating rules and regulations.
7. No physical punishment is permitted. Striking a participant is prohibited. If a participant is violent and potentially dangerous to themselves or others, the police should be called.
8. Isolation or "time-out" from an activity may be utilized but only for a short time. Isolation should be a way of helping the participant get control. It is not for the purpose of restricting from an activity.
9. Be sure that all staff employ the same behavior management techniques. Consistency is crucial.

(Continued)

(Exhibit 5-4: Operating Policies and Procedures--Participants--Continued)

PARENT/GUARDIAN COMMUNICATION

Staff are responsible for informing parents/guardians of program activities affecting their respective participants.

Communication with parents/guardians includes:

1. Notification of upcoming special events, field trips.
2. Advanced notification (minimum of seven days for summer programs and two weeks for seasonal programs) if any changes are to take place in program location, time, transportation, spending monies, clothing/attire, activity equipment.
3. Immediate notification of an injury or behavior incident or program activity causing clothing/equipment to need cleaning or care.
4. Immediate call if participant misses two or more consecutive programs without prior notice.

Communication procedures:

1. Staff are to send mail, following supervisor review, to parents/guardians from the NSSRA (Northern Suburban Special Recreation Association) offices.
2. Staff are to report to their supervisor contacts made by parents/guardians to any NSSRA staff.
3. Staff are discouraged from either calling or giving their phone numbers to participants without the consent of parents/guardians or awareness of NSSRA staff.

INJURY TO PARTICIPANT

1. All full-time staff must be certified in first aid and CPR.
2. In the event that an accident/medical emergency should occur causing injury to a participant or staff, First Aid should be administered immediately.
3. If the injury is of a serious nature, paramedics should be called to the site.
   When help is called, tell:
    a. Where the emergency situation is (cross streets)
    b. Phone number you are calling from
    c. What happened
    d. How many persons need help
    e. What is being done for the victims

   Hang up last; let the person you are calling hang up first.
4. After calling the emergency services, call NSSRA offices immediately. NSSRA administration will notify parents/guardians and keep them updated on the situation.
5. The staff member in charge shall wait with the accident victim while other participants are being supervised by other staff who will continue the program.
6. If medical authorities advise taking the victim to a hospital, the nurse or staff member in charge shall accompany the victim to the hospital and remain with the victim until parents/guardians arrive to take charge of the patient.
7. An accident report form shall be filled out and submitted to NSSRA offices by the staff member in charge within 24 hours of the accident.

(Continued)

(Exhibit 5-4: Operating Policies and Procedures--Participants--Continued)

8. If the injuries are not severe, but the on-site supervisor feels that the injured participant should go home:

   a. Contact the parent/guardian to explain the injury and determine if the participant can be picked up.
   b. Contact NSSRA office immediately following to inform of the accident and action taken.
   c. Complete an accident report form and submit within 24 hours to the NSSRA offices.

9. If the injuries are not severe, and the on-site supervisor feels that the injured participant may stay at the program:

   a. Notify the parent/guardian at pick-up/drop-off time of injuries and the applied first aid measures.
   b. Complete an accident report form and submit within 24 hours to the NSSRA offices.

MEDICATION PROCEDURES

1. Prescribed medication is dispensed during program operation hours according to dosage on original container labels.
2. Full-time staff or their designee are to dispense the medication.
3. A minimum of one other person is to witness the administration.
4. Each administration is to be recorded in the "meds" book in ink by date, medication, amount, time, administrator, witness (signatures).
5. During programs, all medications are to be stored in a container so marked. This container is to be placed in a safe location secured from participants.
6. Full-time staff or their designee are to supervise the transport of the medication container during NSSRA programs.
7. In the "meds" container a hard bound "meds" book is to be retained for recording administration.
8. The total number of pills or liquid amounts are to be recorded per participant in the "meds" book pre- and postprogram by the full-time NSSRA staff member or designee.
9. Medication consent forms and administration forms are to be retained with the "meds" container during program operation.
10. If an emergency arises during a program, the NSSRA staff or their designee sees that medication, medication records, and forms are managed so the participant receives necessary care and proper persons are notified.
11. Any foods or specific beverages used to administer the medication must be sent by the parent/guardian.

SECTION B: RISK MANAGEMENT PLAN

Introduction

A risk management plan identifies and manages risks associated with the delivery of and participation in leisure services. Use of risk management procedures allows the staff to identify the hazards or elements of danger associated with an experience and to establish alternative policies and procedures to alleviate or minimize the risks associated with service operation. Concern for managing risks has come from several sources: an awareness of operational problems that result in financial loss to the agency, such as electrical problems which cause damage to swimming pool pumps; increased fiscal conservatism; an increasingly claims-conscious public; rising insurance premiums; placement of persons with greater functioning deficits in the community; and increasing demands being placed on already limited numbers of personnel and physical resources. When designed and adhered to by staff a risk management plan becomes a primary and effective means for managing risk.

The agency may choose to pay some claims from its own budget to keep down the costs of insurance or may turn all claims over to its insurance company or lawyer for payment or settlement. With the increasing costs of insurance premiums and legal advice, agencies have created "risk manager" positions to identify and eliminate as many risks as possible. An employee may choose to supplement the agency's liability coverage by purchasing a separate policy through a professional organization or as an addition to the employee's homeowner's policy. The responsibility lies with all staff, first, to identify and evaluate the risks present in a program or activity, and then, to prepare and carry out a plan which actively minimizes these risks.

Risk Management Mind Set

Risk management is a mind set or philosophy and, as such, is at the foundation of all decisions regarding staff hiring, program design and evaluation, management of resources, and staff interaction with participants. Seeing a gym door left open at a time when it should be locked should trigger an employee to feel responsible to secure the site if another staff person is not present. When a parent or professional colleague reports a concern, appropriate information sharing and corrective action should result. When an employee does not report to a worksite, leaving a program under-staffed, the rest of the staff should automatically shift to cover the program area. If a participant appears unable to demonstrate the appropriate skills needed for a particular activity, the activity progressions should be restudied to determine a more appropriate placement for the participant. These are examples of actions which will be present when concern for safety and quality control of services are accepted as staff responsibilities.

Staff must be aware that programs are influenced by many factors, such as the condition of the equipment or the mood of a participant. Procedures to follow when illness, accident, injury, or emergencies occur are prepared and practiced. Supervision and staff training are consistently offered and evaluated. Accurate record keeping and reporting are required. Programs are modified in view of new information or as a result of unanticipated happenings. Information dissemination is accurate, timely, and shared with the appropriate audiences. Program decisions are based on clearly stated, measurable objectives. Concern for the well-being of participants, resources, and self is the motivation for initiating risk management practices, rather than doing so only out of fear of a negligence suit being filed against oneself or the agency.

Before a specific activity or program is put into place, it is the manager's responsibility to prepare a written plan which includes appropriate back-up material and contingency (alternate) activities. Then, during staff in-services, the plan is discussed and practiced before it is incorporated into the ongoing schedule.

Literature defines the process of risk management as: 1) identifying risk sources; 2) evaluating the possibility of risk actually occurring; 3) determining how to manage risks; and 4) implementing and evaluating risk management processes. In a therapeutic recreation program, the information gained during the assessment phase is used to identify the potential risk factors associated with the population, the agency, and the community. Then, program policies and procedures are written, safety and quality control measures are planned and implemented, and continuous evaluations and inspections are conducted to assure compliance. A risk management plan focuses on staff, participants, and programs.

Staff

Work responsibilities are analyzed to define staff competencies and performance criteria; these are then used to write job descriptions. Staff are hired and evaluated using these standards. In some instances qualifications may be verified by the possession of credentials in specific areas, such as adapted aquatics, defensive driving, emergency medical technician, first aid, and certified therapeutic recreation specialist or assistant (NCTRC classifications).

During the interview, potential staff members should be told that references will be contacted, credentials reviewed, and transcripts studied to assure that the applicant possesses the reported qualifications. Police and credit checks may be made to assure that potential staff are law-abiding and have demonstrated an ability to manage money. The intent is to prevent unpleasant experiences. For example, participants with emotional disorders or limited ADL skills may become unmanageable and dangerous to themselves and others. In such a situation, a staff member who needs to apply physical restraint to a participant could be open to accusations of abuse. The manager who has completed a thorough personal review of the staff member during hiring has demonstrated "reasonable effort" to assure staff competence and ability to manage routine job expectations. Likewise, knowing that a staff member has no past record of financial mismanagement reduces the likelihood of problems arising over the handling of participant monies during field trips.

Staff training and development programs must include the following topics: systematic program design and evaluation; safety; supervision; participant functioning as relates to program demands; proper documentation; emergency responsiveness; specialized needs of persons with disabilities, such as medication, physical assistance, and behavior intervention; specialized recreation skill training; and communication and information sharing. Staff must first be involved in writing the regulations and, second, must evaluate their own compliance with these policies. When staff have had input into the making of the rules, they are more likely to support and adhere to them.

A plan of supervision (see Exhibit 5-5) identifies the leadership responsibilities, staff-participant ratios, inspection and securing procedures, emergency actions, specific precautions to be taken with designated participants or activities, use of safety plans and equipment, participant management techniques, and procedures to report resource conditions. Staff should be thoroughly familiar with emergency forms, participant abilities in particular activities, and the proper and improper use of a specific activity or piece of equipment. It is very important to acquaint staff with those risks possible during a program, such as the incidence of seizures, allergic reactions, heart failure, the possibility of a participant's death, and the vulnerability associated with their role as helper or therapeutic agent.

Participation in a successful, satisfying swim program requires a carefully prepared plan of supervision that addresses all aspects of risk.

Exhibit 5-5
PLAN OF SUPERVISION

SWIM PROGRAMS

1. Upon arriving at the pool, check area for safety - toys and equipment out of pool, rest rooms in good condition, lights on, pool deck clear.
2. Check to make sure baskets in proper area - review dressing room assignments with staff.
3. Check chlorine level, pH level, heater temperature, and air temperature; consult office if problem.
4. Check to see if chlorinator is on and the timing device is set correctly.
5. Make sure all needed equipment is out and staff have it set out for their swimmers.
6. Have emergency phone numbers available and rehearse emergency procedures.
7. Review attendance and lesson plans; determine teaching sites in pool and staff-participant assignments.
8. Oversee safety of program; review safety precautions with participants/staff.
9. Identify to the guard any swimmers with potential problems.
10. Assist swim staff with techniques, program activity ideas, and safety consciousness.
11. Scan water, listen for change in noise level, and if you sense a problem, check to see guard is aware of situation.
12. If you recognize a problem situation, watch from the deck.
13. Review participants who have seizures, medical problems; make sure staff and guard know the safety procedures for seizures and heart conditions and have mat ready in case of seizures.
14. Assist with exit and dressing, if needed.
15. Put away equipment.
16. If staff leave pool area, guard must be present and appropriate doors locked and pool areas must be secure.
17. Stay in pool area until participants leave, secure all entry-exit ways.
18. Complete evaluation forms.

Persons who have not had formal training on the primary and secondary consequences of disabilities, especially in emergency or health-related situations, become potential risk factors themselves. All personnel, including volunteers, interns, secretaries, maintenance, and security staff, should be given in-service trainings on seizures, the side effects of medications, management of resistive or uncontrollable behaviors, operation of assistive devices, alternate communication methods, and disorder-related behaviors. Such training gives the agency a defensible position in liability cases. A lifeguard may be qualified to perform aquatic duties via credentials held, yet may have had little formal training with water-related emergencies involving persons with disabilities. One approach is to prepare a cooperative responsibility list describing the roles of therapeutic staff and lifeguard staff (see Exhibit 5-6). Conducting in-services on these topics and documenting those in attendance serves as a risk management tool.

Exhibit 5-6
AQUATIC POLICY

1. The guard, or person on the deck watching the pool, is ultimately responsible for swimmers, volunteers, and staff safety.
2. The guard is responsible for safety practices.
    a. As the responsible person, the guard has the right to question the NSSRA staff regarding safety of participants.
    b. If there is a discrepancy between the NSSRA staff's and guard's views, the guard should identify the most reasonable safety measures with NSSRA staff adapting their participants' management techniques.
3. The NSSRA staff is responsible for participants' instruction and activities - unless the guard feels they are being unsafe.
4. The NSSRA staff is responsible for equipment (getting it out, putting it away, maintenance, etc.).
5. The NSSRA staff is responsible for notifying the guard of any special problems the participants may have (seizures, heart problems).
6. The guard is responsible for instructing the NSSRA staff of regulations when necessary (e.g., wearing appropriate swim attire). The NSSRA staff is then responsible for seeing that these regulations are met.
7. The guard and NSSRA staff should work together in a cooperative manner to provide adequate safety and services. Problems that cannot be solved by the guard or NSSRA staff should be directed to the appropriate supervisory staff.
8. NSSRA staff are responsible for assuring that their participants comply with posted pool rules and guard requests. Guards may assist NSSRA staff by, for instance, making emergency phone calls if NSSRA staff request assistance.

Participants

Managing risk with therapeutic recreation participants requires that attention be given to documentation of their abilities, their actual performance in programs, and the conditions surrounding their participation. An essential aspect of the registration process is the complete disclosure of the program content and participatory requirements to the participants and caregivers. This is accomplished through releases or waiver statements and participant assessments. A common practice is to require participants or their guardians to sign that they have read and received copies of safety precautions and participant guidelines (see Exhibit 5-7).

Exhibit 5-7
PARTICIPATION GUIDELINES

To assure each participant's safety during programs, each participant and/or their guardian must:

1. Complete and update the following NSSRA forms prior to program delivery:
   Consent for Participation and Emergency Medical Treatment Annual
   Information Form
   Registration Form
2. Utilize staff recommendations regarding program alternatives.
3. Either assume responsibility for personal medication or comply with NSSRA procedures for handling medication needs during program participation.
4. Assure that NSSRA staff are aware of essential self-care needs.
5. Provide information on and/or assistance with participant behavior management needs.

Participants are placed in appropriate programs as determined by the results of their needs assessments. Achievement of their individual objectives is monitored and documented. Progression and transition among programs is based on staff evaluation of participants. However, it is just as important to document that participants practice emergency drills and adhere to program policies as it is to document their skill development. Staff is familiar with and has ready access to the health records of each participant. All communication with participants pertaining to their performance or their health and safety is properly recorded by the staff and follows agency protocol (see Exhibit 5-8).

Exhibit 5-8
PARTICIPANT INFORMATION LIST

At all times, the program director is to have a complete and accurate participant information list on hand and available to all program staff. The program director is responsible for updating the list and making corrections in the event of any medication, telephone, or address changes.
The participant information list should include the following:

1. Participant's name and birthdate
2. Participant's address, zip code, and home telephone number
3. Participant's and/or parent's work telephone number
4. Alternate emergency telephone number and contact person
5. Physician's name and telephone number
6. Medical information, including seizures, date of last seizure, communicable diseases, atlantoaxial dislocation, dietary restrictions, physical conditions (hemiplegia, heart conditions, etc.), any activity restrictions, medications being taken and their possible side effects
7. Photo release

Program

Written safety and use procedures are properly posted and are reviewed with participants before each program or session as necessary. Maintenance and security checks are part of the routine opening and closing procedures; deficiencies and follow-up actions are documented (see Exhibit 5-9). Ongoing inventories are used to record the condition of materials and are properly filed. Programs are conducted according to preplanned outlines; however, when specific adjustments are found to be necessary during a program, these are noted immediately following their implementation. Program evaluation is done to document achievement of participant objectives. If an activity or the use of a piece of equipment involves risk, staff are held responsible to train participants in the proper techniques. When an experience demands certain skill levels for successful safe performance, prerequisite skills are stated on the program plans.

For participants who have functioning limitations, leaders must alter various program features, such as rules, equipment, or participant skill level requirements, to foster success. Training staff to adapt experiences is an ongoing task. Adaptation techniques appropriate to the activities are written directly on the program planning forms. Additionally, staff are briefed and given proper program precautions to follow so they will know what to do when specific conditions, such as a very hot day, make the activity unwise.

Other conditions influencing program delivery are: staff-participant ratios, medication schedules, accessibility, participant activity before and after therapeutic recreation participation, caregiver responsiveness, transportation, dietary needs, and the use of adaptive equipment and/or orthopedic devices. Contingency plans to handle specialized needs must be designed. To illustrate: visual alarm warnings must be designed to accompany audible sirens; extra change is carried by staff to make emergency phone calls; additional staff are on deck while the teaching staff are in the pool with seizure-prone swimmers (see Exhibit 5-10); sun visors and sunscreen lotions are used to protect the participants against overexposure to the sun; a portable first aid kit is carried; and alternative entry-exit routes and techniques are planned and practiced.

Ramps help make playground equipment accessible to all participants.

Exhibit 5-9
SITE SAFETY ACCESSIBILITY INSPECTION CRITERIA

Directions: If the standard has been met check "yes." If the standard is either not currently met or one that cannot be met, check "no" and if the standard will be met by certain date, identify compliance date. If the standard is not applicable check below the "N/A" column.

ENTRIES/EXITS:

Yes	No	N/A	Compliance Date	
				Building entrances are unobstructed.
				Secondary exits have panic bars.
				Exits and aisles are unobstructed and marked as exits.
				Exits are clearly lit.

BUILDING/GROUNDS:

Yes	No	N/A	Compliance Date	
				Glass is unbroken, uncracked, and nonmistakable as window or exit.
				Floor surfaces are nonslippery and free from tripping hazards.
				Stairways are equipped with treads and handrails and are well lit.
				Emergency and security lighting is installed and unbroken.
				Sidewalks, steps, parking lots are lighted, marked, smooth, not cracked or broken.
				Fencing is not torn, broken or bent. Rules are posted in activity areas.
				Emergency phone numbers are near phone and procedures are posted.
				Smoking is prohibited and enforced.
				First aid kit is stocked and accessible.

OPERATING CODES AND INSPECTIONS:

Yes	No	N/A	Compliance Date	
				Alarm systems are inspected annually/biannually.
				Smoke detectors are inspected annually/biannually.
				Fire extinguishers are inspected annually/biannually.
				Elevators are inspected annually/biannually.
				Sprinkler systems are inspected annually/biannually.

(Continued)

(Exhibit 5-9: Site Safety Accessibility Inspection Criteria--Continued)

POOLS:

Yes	No	N/A	Compliance Date	
				Qualified lifeguards are on duty.
				Lifeguards are trained on pool needs of special populations like seizures, bowel/bladder control methods, use of helmets.
				Controlled fences enclose pool.
				Pool depths are marked and sectioned off when used by special populations.
				Safety equipment is readily available.

STORAGE AND MAINTENANCE:

Yes	No	N/A	Compliance Date	
				Materials/equipment are stored in pre-designated, marked, well lit, secured/protected areas.
				Materials/equipment are transported and organized at the program site so participant access is limited and/or controlled.
				Combustible or hazardous substances or foods to which participants could react are labeled and stored separately from other program supplies.
				Concealed spaces or closets are marked, secured, clean and neat.
				Areas are clear of debris and waste.
				Waste is removed regularly.
				Covered receptacles are provided for disposal of garbage and empty combustible containers.

ACCESSIBILITY STANDARDS:

ANSI (American National Standards Institute) criteria are in compliance in the following areas:

Yes	No	N/A	Compliance Date	
				Corridor
				Ramps
				Doors
				Work/kitchen areas
				Outdoor areas
				Parking/access
				Pools
				Rest rooms
				Showers
				Signage
				Stairs
				Telephones
				Warning signals
				Water fountains

Exhibit 5-10

SPECIFIC CONSIDERATIONS FOR SEIZURES IN AN AQUATIC ENVIRONMENT

A. Calling the Emergency Squad.

1. Call the ambulance; call the police.
2. Tell them:
    - a) what you need
    - b) who you are
    - c) where you are, giving the exact address
    - d) the telephone number from which you are calling
    - e) exact directions for access to the pool
    - f) the condition of the individual
    - Note: g) You hang up last.
3. Assemble emergency information for the Emergency Squad (medications, emergency list).
4. Send someone outside to help direct the Emergency Squad to the pool entrance.
5. See if you are needed to assist the individual.
6. Send someone to notify the main office who will then notify the parent or relative.
7. Assign staff to assist the other participants.

B. Designing a safe aquatic environment

1. Remove physical objects from the deck and dressing area which could be a hazard during a seizure.
2. Designate a specific area to store a mat or blanket which is used to protect the individual from the concrete deck.
3. Maintain appropriate water and air temperatures in the pool and the dressing rooms (water, 86-90°; air, 82-86°) because extreme changes from one to the other may cause seizures.
4. The therapeutic staff and the lifeguard staff will work together during an emergency.
5. Staff are to observe the characteristics and behavior of their assigned swimmers upon their arrival for each day's program.

C. Entering the water

1. One to one staff/swimmer ratio will be maintained during entrance to and exit from the pool.
2. Participants wearing helmets will remove the helmet after entering the pool and will replace the helmet prior to exiting the pool. Helmets will be placed accessibly near the pool while not in use.
3. Staff will do the following:
    - a. Maintain eye contact with the swimmers.
    - b. Watch breathing patterns for hyperventilation (while stationary and while swimming).
    - c. Be aware of the water temperature and whether the water is too cold or too warm.
    - d. Be aware of hot muggy conditions.
    - e. Watch for changes in the normal swim and/or behavior patterns of swimmers.
    - f. Be able to distinguish the difference between a drop seizure and a prone float and/or bob. The difference is often not detected because drop seizures happen quickly and quietly.

(Continued)

(Exhibit 5-10: Specific Considerations for Seizures in an Aquatic Environment--Continued)

D. Procedures to follow when a seizure occurs in the water
   1. Petit mal (absence) and grand mal (tonic-clonic) seizures
      a. Get the individual's face above the water and the head tilted back. Keep the individual away from the wall.
      b. Look, listen, and feel for breathing. If the individual is not breathing, give mouth to mouth or mouth to nose resuscitation immediately.
      c. Talk calmly to reassure the individual.
      d. Time all seizures. Record and pass on to the appropriate individuals.
   2. Specific instructions for petit mal (absence) seizures
      a. Keep the individual in the water.
      b. After recovery the individual may stay in the water unless a second seizure is experienced.
      c. Wait for that recovery and when the individual is responding, assist with exit.
   3. Specific instructions for grand mal (tonic-clonic) seizures
      a. Maintain the individual's head above the water throughout the seizure.
      b. Remove the individual from the water after the seizure is completed.

Conclusion

Management of risk is an ongoing agency and personal responsibility. Some larger communities and therapeutic recreation departments may employ or appoint a risk manager or a safety training officer to specifically deal with risk detection and correction. Policies and procedures for safety are placed in the department or agency handbook or manual. During new employee orientation, a portion of time is designated for review of safety guidelines and staff responsibilities. Staff training may include basic first aid and CPR as well as a review of emergency procedures.

Staff, participant, and program policies and procedures must reflect awareness of safety and quality control. Staff are responsible for immediately reporting hazards or needed repairs, especially if another group or activity is scheduled in the same area. Therefore, it is important that staff know which person in what department should be called or where the maintenance crew is currently assigned in case a quick repair is needed. Participant safety guidelines are included in the policy statement. Routine checks are made of program areas, activities, and the conditions influencing the experience. One recommendation is to include on weekly or event report forms a place for staff to report risk management concerns (see Exhibit 5-11). This serves as a reminder that safety awareness is a staff responsibility.

Exhibit 5-11

RECREATION CENTER

Weekly Staff Events Report
Week of: ________________
Name: __________________

I. Meetings (please give date, time, and location) PREVIOUS WEEK

II. Programs (regular)

III. Programs (special events)

IV. Supplies to be ordered (two weeks in advance)

V. Risk Management
   A. Personnel (problems, recommendations, absences)

   B. Participants (problems, recommendations)

   C. Program

   D. Facility (maintenance, repair)

   E. Administration

SECTION C: STAFF TRAINING AND DEVELOPMENT PROGRAM

Introduction

A staff training and development program encompasses two broad components. Training considers staff needs in relation to the demands of the employment situation. Development addresses the personal and professional nature of a career and is intended to equip staff members with the skills and resources needed to foster their continuous growth as professionals, beyond the day to day job demands.

To accomplish these major goals, a training and development program generally has five phases. 1) Orientation occurs from the moment of initial contact through the first few weeks or possibly even months of employment. 2) Pre-service (pre-camp or pre-season) or specialized in-service addresses pre-program or seasonal concerns. 3) In-service focuses on the information needed on the job and occurs through regularly scheduled staff meetings, workshops, or courses which are usually coordinated by the agency. 4) Specialized institutes, conferences, and professional meetings coordinated by professional and/or educational institutions enable professionals to remain abreast of career issues and trends. 5) Supervision and evaluation is an ongoing process conducted through observations by and individual conferences with agency supervisors.

A training and development program must serve all staff, including full-time, part-time, seasonal, student interns, and volunteers, whether or not they have had experience in recreation, therapeutic recreation, and community based programs. The program is designed around the needs of the job, the department, the agency, the community, the participants, and the staff.

The first step in designing a training and development program is to complete a task analysis to determine the skills needed by the staff to perform their designated job functions. Existing job descriptions, staff performance documents, and professional curricular materials aid in identifying job tasks. From this delineation of job tasks, staff performance objectives are prepared. These statements serve as criteria to evaluate the presence or lack of specific skills and knowledge on the part of the staff. The final step in the preparation process is to determine the content of the training and development program and to select appropriate procedures and tools to best implement the program.

To determine an appropriate mixture of training and development, ongoing assessments are made of staff to compare their existing skills and needs to the job expectations identified through the task analysis. Content is organized into plausible training units or appropriate development opportunities. Each staff member, whether they be full-time with ten years of experience or a college student employed only during summer programs, has unique job-related skills and needs and gains professional maturity through a training and development program.

Dealing with volunteers is multifaceted. Volunteers are a resource to be utilized in the training and development of other staff. The effective use of volunteers is also a subject to be included in the staff training program. And the volunteers themselves must be trained.

The training of volunteers is a major staff responsibility. Their length of stay and the services they will perform influence the number of and the topics included in the training sessions designed specifically for them. To illustrate, when a civic group requests a one-time volunteer opportunity, a single intensive training session is generally designed; but when volunteers make a long-term commitment, training will generally include orientation, in-service, and evaluation over the duration of their stay. Volunteer availability may dictate the scheduling of such sessions. Terms in the volunteer contract specify their working conditions, including the training meetings they will attend and the supervision under which they will work (see Appendix D).

Program Design

A staff training and development program is designed to meet a variety of staff needs. Generally, the program is intended to increase the employee's understanding of job responsibilities, to improve job-related skills, to ensure continued growth relevant to both employer and employee needs, to foster employee interest in and support of the agency and its efforts, and to maintain a satisfied and motivated employee who consistently demonstrates specific employee behaviors, such as good work habits, a positive attitude toward the job, and application of information or knowledge to daily activities on the job (see Exhibit 5-12). Because of the evolving nature of therapeutic recreation, a systematic, ongoing education program which encourages formal as well as informal training is essential.

Training and development needs are also ascertained by studying completed population, agency, and community assessments. These assessments yield information on the past, present, and anticipated resources and needs of the participants, the agency, and the public. Additional sources of training and development content include: standard health, safety, emergency, and risk management precautions; guidelines of professional bodies and reports from research projects, such as LIFE (Leisure Is For Everyone). Topics discussed at various management schools and in professional journals and meetings also offer timely ideas.

Volunteers who teach special activities, such as skiing, need training that includes orientation, in-service, and evaluation over the duration of their commitment.

Exhibit 5-12

RECREATION COMMISSION

Division: PERSONNEL

Subject: GUIDELINES FOR TRAINING SESSIONS

INTRODUCTION: The main purpose of these guidelines will be to standardize department in-service training programs. In addition, this format will require advanced planning on the part of the Instructor and will facilitate the development of periodic department training catalogues. Also, participants and supervisor will have a better idea of the session content and this will assist individuals in career guidance and employee development. Lastly, by following these guidelines, an Instructor will have completed a majority of the requirements for the awarding of Continuing Education Units.

SESSION TITLE: Briefly list the session title, being specific as to the type of training. This will be the listing which will appear in the periodic training catalogues and will identify your session from others which will be given.

SESSION PARTICULARS: Clearly state the date, time, location and instructor for the session. Also, list a phone number of person to contact should a participant be unable to attend.

DESIGNED FOR: List by job title or specific designation the target audience for which the session was designed. If the session applies to all levels, list the particular target audience you are attempting to reach.

OBJECTIVES: List briefly the objectives of the session. By completing this instruction, what will a participant be able to do? What new skills will he/she develop? How will the session assist the employee in doing a better job?

DELIVERY METHODS: What training techniques and devices will be used to present the material?

EVALUATION TOOLS: Specifically list the evaluation tools which will be used in the session. Will there be a written test or a form for participant comments? Will the instructor evaluate the progress of participants or will there be a follow-up questionnaire after a period of time?

TOPICS COVERED: List very briefly in outline form, the topics to be covered during the session.

To discover other possible training needs, a review may be made of existing agency documents, including: employee education and professional background data; participant program records; previous employee appraisals; operating and personnel policy manuals; governing documents and specific regulatory codes, such as the charter and bylaws and risk management policies; summary or annual reports; and master plans. Other sources of information include interviewing and observing staff within the therapeutic program, reviewing printed literature about professional meetings, and studying evaluations (see Exhibit 5-13) from past trainings. Risk management supports the maintenance of an up-to-date record of the training and development sessions in which the staff have participated.

Utilization of the following accepted learning principles fosters learning and retention of the material covered in the training and development program:

1. Place factual material, such as the agency's or program's history, in print.
2. Explain why it is important to do the job correctly.
3. Establish individual staff objectives with criteria applicable to on-the-job performance.
4. Plan on-the-job observations to evaluate accomplishment of individual staff objectives.
5. Sequence instruction from the general to the specific. First, describe the whole skill, then demonstrate the steps involved. To illustrate, if staff are acquiring behavior management skills, such as the use of "time out," first explain the complete procedure, then demonstrate the steps from the point of inappropriate behavior display through physical removal to re-entry of the participant into the activity.
6. Consider how frequently a particular skill is needed by staff to perform effectively as therapeutic recreators; then establish a commensurate amount of time to teach the skill. Activity and leadership adaptation is a frequently needed skill; whereas skill in completing proper equipment inventories is not as frequently used.
7. Consider the criticalness of skills for the health and safety of staff and participants. Proper handling of seizures is far more essential to a participant's well-being than is an in-depth knowledge of environmental barriers and should therefore be a routine topic of training.
8. Appeal to the primary senses of sight, touch, and hearing by using "hands on" experiences and real participants to authenticate the demonstrated activities. Video tape the training sessions to permit staff to see themselves practicing the skills. Use footage of actual programs to illustrate particular points.
9. Present both correct and incorrect ways of completing agency forms. Give staff the opportunity to use the forms to report an actual account, such as an incident report. Include in the session the importance of the proper selection and use of all forms, particularly those related to health and safety.
10. Designate training and development priorities each fiscal or calendar year. Establish a budget to cover these expenses.
11. Prepare a training calendar. Highlight local, regional, state, and national professional opportunities.
12. Offer training in the off-season. October through February is generally more conducive to employee participation than are time periods when heavily-attended seasonal programs and vacations occur.

13. Utilize people from within the agency as trainers and resource persons. Being responsible to teach a skill is a positive learning experience for any staff member.

14. Network with other agencies whose employees may be willing to serve as training consultants. These mutual exchanges enhance training opportunities among agencies throughout the community.

Exhibit 5-13

TR TRAINING SESSION EVALUATION FORM

Session Title: ____________________

Name of Speaker: ____________________

Number of years worked: ____________________

1st yr. ___ 2nd yr. ___ 3rd yr. ___ more than 3 yrs. ___

What do you want to learn from this session:

1. ____________________

2. ____________________

3. ____________________

Please rate the following items. Circle the number on the continuum which best reflects your opinion.

1. Were your above stated expectations met?

1 2 3 4 5

not at all — very much

2. How knowledgeable were you on the content of this session before attending training?

1 2 3 4 5

little prior knowledge — very knowledgeable

3. How much did you learn from this session?

1 2 3 4 5

very little — very much

(Continued)

(Exhibit 5-13: TR Training Session Evaluation Form--Continued)

4. How interesting was the session?

1	2	3	4	5
of no interest				very interesting

5. How knowledgeable was the speaker?

1	2	3	4	5
not very knowledgeable				very knowledgeable

6. How important is it to include the content of this session in next year's training?

1	2	3	4	5
not important				very important

Was this session valuable to you personally? Why or why not. ______________________________

Do you require more training? Yes __ No __

Additional Comments: ______________________________

Training Content

Training content varies according to the existing competencies of the staff. The backgrounds of seasonal and part-time staff are generally more diverse than are those of permanent employees. Consequently, the orientation and preservice phases for summer and hourly staff will cover a broader range of information on the entire agency and its services and will be directed more toward specific program areas, but will be in less depth. The educational background and experience of full-time employees may include recreation and related fields, such as special education, psychology, and health service areas. Those with general recreation backgrounds must be introduced to working with persons who are disabled. Those with special education and health-related backgrounds must be introduced to leadership principles specific to therapeutic recreation activities (see Exhibit 5-14). And all staff must be made familiar with the department's operating procedures, safety concerns, and philosophy.

Exhibit 5-14
SAMPLE TRAINING HANDOUT

Effective Leadership

- Before beginning any type of instruction for an activity, get everyone's attention.
- Make the instruction in itself fun; if the leader is slightly entertaining, it's much easier to get everyone's attention.
- When giving instructions it's best to use words like "let's try" rather than "now we're going to." It sounds more inviting.

Generally the procedure for introducing an activity is:

1. State the name of the activity.
2. Combine description with demonstrations, use visual directions as well as verbal directions whenever possible.
3. Allow the participants to practice any special actions or motions that they will be performing.
4. Have the whole group practice the activity, walking through it prior to starting the game.
5. If a participant makes an error, don't single out that person; repeat the demonstration or description followed by another practice.

- It may be necessary to break an activity down into more simple components. Teach the skills needed to play an activity step by step. Perhaps each step can be made a game in itself.
- Simplify all rules and regulations of a game if they are not safety related. The best games are those that have only a few rules.
- Identify those participants who are easily motivated first and get them to carry the game until everyone else gets involved.
- If a game is competitive in nature it may be necessary to neutralize the dominant players to equalize the group. Alter their role within the game.
- Consider your game formation with the type of interaction you're providing.
- Dual/partner type games are great for those participants who are shy or reluctant to participate in a large group activity. You can almost always find one or two individuals with whom a participant will interact.
- Circle games create group awareness and generate the most group interaction. Circle games also provide the leader with the most control. (The leader should stand as part of the circle, not in the middle.)

(Continued)

(Exhibit 5-14: Sample Training Handout--Continued)

- Before starting an activity, have some possible adaptations or adjustments in mind. Anticipate what the difficult part of the activity is and plan some simplifications.
- Be aware of your activity sequence and the progression of the games. Gradually build to the more active games. Have some quiet games interjected to permit participants to regain control.
- Minimize the delay between activities; once the play is started and the participants are involved keep it going. If you have to stop and start all over again you may lose them. Plan activities that allow for a quick transition from one to another.
- Try to identify the fun element of an activity and do everything you can to emphasize that element.
- Plan more activities than you think you could possibly need. Allow for shorter attention spans as your activities will not hold interests as long as you expect.
- Never play a game too long or too often. If you play the game until everyone is bored, they won't remember how fun it was when you first started. It's better to stop early and leave them wanting more and anxious to play again next time.
- Always observe your participants when engaged in an activity. Study their reactions to various types of games. Their idea of what is fun may be very different from yours.

Finally, enthusiasm is still the most important element of leadership. No matter what the activity, an enthusiastic leader makes it better.

Content of a training program may include but is not limited to the following topics:

ORIENTATION CONTENT

Agency philosophy, goals, objectives, policies, and procedures
Agency organization, hierarchy, and chain of command
Agency protocol; written and unwritten codes of conduct and performance
Appropriate participant terminology
Agency staff and facilities; location of support personnel and resources
New employee forms, such as medical, insurance, parking, and staff identification
Job regulations from the personnel manual, such as work hours, sick leave, staff-participant ratios, transporting of participants, and the staff evaluation process
Budget and funding, expenditure of personal and petty cash monies, and purchase of program supplies
Emergency and participant safety procedures
Introduction to the agency's services and constituents
Introduction to the purposes and goals of the therapeutic recreation department

PRE-SERVICE AND IN-SERVICE CONTENT

Securing community resources, such as specialists, volunteers, contributions, and information
Factors influencing the delivery of services, such as politics, funding, transportation, networking, accessibility, and legal needs and implications

Participant characteristics, dynamics, interests, functional ability levels, and special considerations
Program philosophy; year-round and seasonal schedules; fees and charges policies; and policies and criteria affecting participation
Marketing the program within the agency and to the community; cooperative and contractual relationships and agreements
Relationship of the therapeutic recreation department's programs to the other programs within the agency and in the community
Integration policies and procedures
Risk management planning
Professional ethics, such as participant confidentiality and autonomy
CPR, first aid, and aquatic certification
Writing of participant and program plans
Using assessment and evaluation instruments
Selecting therapeutic activities through activity and task analyses
Programming and activity ideas; special event planning
Professional philosophy as it relates to the service continuum of therapeutic recreation, leisure education, and recreation participation; transitional planning
Writing measurable objectives; developing activity sequences within a program and between programs; documenting measurable results
Assisting participants with ADL (activities of daily living), such as posturing and dressing
Developing recreation programs to accommodate IEPs (individual education plans) and IPPs (individual program plans)
Adapting activities, equipment, and leadership techniques
Operation of orthopedic and prosthetic devices, such as mobility equipment, hearing aids, and communication devices
Leadership and specialized intervention techniques, such as reality orientation, behavior management, and range of motion exercises
Creative programming, especially with severely, profoundly, and multiply involved participants
Volunteer supervision and management
Communication with caregivers, teachers, and support groups
Sign language
Registration forms and processes
Health concerns, such as seizures and diabetic reactions
Funding special projects and programs
Facility design and accessibility
Advocacy and legislation
Technology and computer applications
Medical terminology; medications, their side effects, and implications for participation
Conducting meetings with advisory groups or project committees
Time management

The following staff attitudes must be developed or emphasized during training:

1. Awareness of the adaptations that need to be made to integrate programs. such as in staffing, medical coverage, and accessibility.

2. Unconditional acceptance of persons with and without disabilities.

3. Awareness of a participant's readiness to transition to another level of programming.

4. Awareness of the attitudinal barriers and misconceptions held by oneself and others, including the participants.

5. Tolerance of the atypical behaviors exhibited by the participants, such as ritualistic rocking, echolalia, tics, teeth grinding, verbalization of four-letter words, and perseveration, since these behaviors may continue despite intervention and regardless of program location.

6. Awareness of when to use confrontive and disciplinary techniques to manage excessive attention getting, manipulative, and self-defeating behaviors of participants.

Staff Development

Professional opportunities are available within the agency and the community. Reading local as well as national newspapers, such as the Wall Street Journal, creates an awareness of community issues and national trends. Attendance at seminars, round table discussions, and agency sponsored workshops offers further growth possibilities. Reading state and national professional journals offers information applicable to work responsibilities. Attendance at regional, state, and national conferences and institutes offers staff the opportunity to acquire up-to-date, job-related information and professional news while increasing their awareness of traditional and innovative professional practices.

Staff development opportunities are widely recognized as an effective motivator and a valuable employment "perk." Attendance at development opportunities benefits the agency as well as the staff. The agency should include in the budget all or part of the employees' expenses and should plan for appropriate staff coverage. If full payment is not possible, alternatives include providing travel expenses, registration reimbursement, or release time. Staff must take the initiative to become professionally involved, with or without full agency financial support.

Supervision and Evaluation

Staff supervision and evaluation is a continual process of communication and human relations intending to assure that staff have been prepared to perform effectively. The supervisor is often in a "middle" position between the agency executives and the front-line leaders. The supervisor depends upon employees to expedite plans conceived by executives or department heads. The supervisor also transmits staff input to the proper administrative level.

The duties of a supervisor include: assuring appropriate use and storage of materials and equipment; documenting attendance and performance; motivating staff to perform well; working to maintain staff morale; planning staffing patterns; providing training and technical assistance; fostering teamwork and cooperation among employees and related services; interpreting agency rules, policies, and procedures; maintaining a safe work environment; managing staff differences; facilitating staff growth and enhancing their performance; recommending promotions, transfers, and special assignments; and performing periodic evaluations.

Implicit in the role of a supervisor is authority. The supervisor balances authority with respect, expecting with accepting. A supervisor separates what a staff person does from who a staff person is. A supervisor works through people. A supervisor allows staff decision-making, supports staff achievement and recognition, and creates an environment in which continuous feedback, learning, and growth occur.

The first step in evaluation is to prepare individual objectives for each staff member. For new employees, this is begun during the orientation period. Staff objectives cover three areas: skill use and acquisition; personal or helper qualities, such as empathy and active listening; and professional job duties and career goals, such as punctuality or attendance at specialized workshops. Review dates and performance criteria are stated with the objectives.

Through formal and informal observations, the supervisor gathers information to determine if the staff are meeting their objectives. Supervisor/staff conferences encourage feedback. Instruments used to evaluate the participants and the programs supplement staff evaluations. The value derived by the staff from evaluation is dependent upon the interpersonal, decision-making, and dissemination skills of the supervisor. Sensitive, deliberate, and accurate sharing of information is vital. Valid, reliable, and objective data interpretation is the sign of a good supervisor.

Conclusion

An assessment of staff skills and needs is used to determine the content of a staff training and development program. As the demands on staff intensify due to budget shortfalls and increased exposure to participants with multiple needs, support of personal-professional staff training and development becomes a must. Release time to attend workshops and research activities, to share successful techniques with other staff, and to "brainstorm" with other professionals in neutral settings is no longer considered a frill but is becoming an essential part of the personnel benefits package.

Managers may complain that staff concerns take up proportionately more of their time than do program concerns. This reflects the importance and ongoing nature of staff supervision. A budget figure often quoted for personnel costs is 60-80 percent of the total budget. A supervisor may expect to give that same percent in time spent on staff training and development.

A supervisor is a role model to the staff, a liaison to the community, an interpreter to and from the administration, and a disciplinarian to the participants. A supervisor must exhibit consistency, support, and professionalism.

SECTION D: MARKETING SERVICES

Introduction

Communication with internal and external audiences affects networking in the community. Staff, administrators, participants, primary caregivers, colleagues, and community resource personnel must be made aware of the nature and purpose of therapeutic recreation in order to gain their support. Also the public must be informed of the agency's services. Effective sharing of information is critical to the prevention of misinformation caused either by false assumptions or lack of accurate information. Because of increasingly higher costs of service delivery, fewer financial resources, and increased fiscal and legal accountability, it is necessary to ensure effective communication among service providers and recipients, funding sources, and decision-makers.

Communication in the Helping Process

Communication is at the core of therapeutic recreation. Through a helping relationship a therapeutic recreator facilitates participant growth and development. Communication is the essence of this helping relationship. The internal audiences with whom a therapeutic recreator must communicate clearly and consistently are: 1) the participants and the participants' support systems; 2) colleagues and team members; 3) agency administrators and policy-makers; and 4) others directly associated with the agency, such as advisory board members. Communication gaps with any of these groups limit effective helping. To illustrate, a staff member, following the program policy of requiring participants to dress without assistance, could be perceived by an unknowing onlooker as being too demanding. If the onlooker interferes, the consequences of the incident could be harmful to the participant's goal of self-care and frustrating to the staff member who is attempting to help the participant.

Poor communication within an agency is often the result of multiple factors. Barriers include physical distance, limited amounts of time, varying knowledge and experiential levels among staff, the multi-layered chain of command, educational and professional differences, lack of a planned feedback process, varying assumptions and meanings applied to concepts by the staff, and the broad service scope.

Written documents are a frequently used form of staff communication. Written communication is essential to: 1) assure consistency in the application of staff intervention techniques; 2) avoid service overlap or gaps; 3) facilitate interdisciplinary team functioning; 4) comply with regulations; 5) deliver accountable services; and 6) effect systematic program development.

Staff also communicate through staff meetings, participant conferences, in-house announcements on bulletin boards, visual displays, and performances. The most influential form of communication is personal contact. It is quick, direct, and powerful. The manner in which staff communicates is as critical as the words they use. To illustrate, the appropriate use of the ignoral technique has beneficial consequences when attempting to eliminate certain undesired behaviors in participants. However, staff avoidance of an advisory member, although done in innocence, may be perceived as a "political cold shoulder" and can have unpleasant consequences if reported to a supervisor.

External audiences are persons who indirectly interface with the program. They are sources of financial resources, volunteer support, program materials, supplies and equipment, opportunities to effect participant transitions and referrals, and community visibility essential to advocate for the needs of participants. Continuous, accurate communication with these audiences can add dollars and cents, as well as participants, to therapeutic recreation programs. A therapeutic recreator has five main external audiences: 1) the general public; 2) politicians and community policy-makers; 3) public media; 4) colleagues in other community agencies; and 5) specific resource or service personnel, such as volunteers, bus drivers, safety personnel, contributors, and vendors. Each audience has vested interests and needs. Also, each serves a unique role within the scheme of therapeutic recreation.

Specific policies or procedures found in the department manual or in administrative directives may govern the communication process (see Exhibit 5-15). The first step in building helpful relationships is the sharing of these guidelines with all appropriate internal and external audiences. Staff must be aware of the guidelines to follow when reporting stories to the media just as the general public must respect the privacy and confidentiality of participant information. Each form of public information, such as radio, television, newspapers, flyers, and brochures, has special uses and audiences. Serving as a host for a tour group, visiting with an elected official, or attending a public hearing offers valuable outlets for the therapeutic recreator to educate others. Each contact must be done according to protocol and with an intent suited to the needs of the particular audience.

Marketing Tools

The primary tools used to transmit information are 1) personal contact, 2) controlled media, and 3) public media. Letter writing, telephone calls, and face-to-face conversations are all forms of personal contact. Controlled forms of media, such as brochures, fact sheets, bulletin boards, displays, slides, films, videos, and newsletters are prepared by the agency or the therapeutic recreation staff. Public media captures the widest audiences and includes radio, television, and newspapers. Each media form has particular pros and cons and target audiences. The following general guidelines apply to the use of all marketing tools:

1. The audience must understand and be interested in the subject. The story must be told in words with which the audience is familiar. The audience must be made to understand the meaning of therapeutic recreation.

Exhibit 5-15
RECREATION COMMISSION

Subject: VERBAL CONTACT WITH NEWSPAPER AND
TELEVISION MEDIA

1. While staff personnel are permitted to directly converse with TV and newspaper media, it should be done with reasonable discretion based upon the sensitivity and complexity of the subject matter.

2. Employees are permitted to discuss with the media questions relating directly to their specific operation including such things as program information, general staff information, operational procedures, etc.

3. Those questions involving specific budgetary items, operational problems, incidents of a sensitive nature, and any divisional or departmental matters or policies (e.g., reorganization, personnel changes) shall not be discussed with the media, but shall be referred directly to the appropriate assistant director's office.

4. When directed sensitive or complex questions, the employee shall politely inform the media person that the question(s) is of a complex nature involving other aspects of the department and that the best approach to receiving the information sought would be to contact the director's office. Supply the media person with the office number.

5. Requests by the media for feature coverage that are made directly to the facility operators or program supervisors may generally be approved, although final clearance must be made through the department office via contact with the administrative assistant in charge of public information materials.

6. Requests by media for feature coverage that may involve controversial or sensitive items must not be granted by the facility operators/program supervisors, etc. but referred directly to the department for discussion and review.

7. In any situation where there is a doubt regarding whether information should be released or not, the media person should be politely referred to the assistant director.

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2. The message must encourage the audience's involvement: "Call Rec-play for further program details," or "Register during August and September for fall programs."

3. The audience must have confidence in the sender of the message. Consistently offering well-managed programs gives credibility to the agency.

4. Communication is a multi-dimensional process. Staff must be responsive to complaints as well as to commendations and must recognize that the person is speaking out of a sincere concern.

5. Communication is a continuous process. Program adjustments made as a result of neighborhood and advisory board meetings, participant input, and professional round tables reflect the changing social, political, and wellness needs of the community.

6. Therapeutic recreators may need to take the lead in educating the media about the concerns unique to dissemination of information about persons with disabilities, such as the

use of release forms, the potentially disruptive effect of visitors on the participants during programs, and the detrimental effect of human interest stories that promote outdated public attitudes toward persons with disabilities.

Personal Contact. Letter writing is a universal form of contact, is relatively inexpensive, and can be adjusted to the situation. Generally, a letter of more than one page in length is probably too long. A potential disadvantage of putting something in writing is that the interpretation of the material might result in misunderstanding and misquoting. It is therefore essential to reread correspondence, thinking how else it might be interpreted.

To assure a prompt reply to incoming correspondence, a system should be set up which includes: dating the correspondence upon its arrival and indicating the response route, the date a reply was sent, and to whom else a copy of the reply was sent. To prevent delays, someone should be designated to take care of correspondence during vacations, out-of-town meetings, or illnesses.

Telephone contact is also direct and prompt but is often time-consuming. Confusion can result when a staff member, a secretary, or a third party takes a message improperly, misplaces the message, hands the message to yet another party, or misinterprets the message. To properly manage incoming telephone calls, a message pad and writing utensils should be placed by each telephone and a location designated to place staff messages. To avoid disrupting staff during programs, a certain time each day should be set aside to place and receive telephone calls. Callers should be encouraged to call back during this time or to leave a message as this allows staff to stay with the participants during programs.

Inquirers expect consistent, accurate responses. Incoming telephone calls should be answered by someone, whether a volunteer, secretary, or paid staff member, who is knowledgeable about the programs and services offered by the agency. Pertinent, descriptive summaries should be close at hand and time should be made at shift changes to update the new phone attendant.

Controlled Media. Brochures are widely used to present program information to both internal and external audiences. Frequent updating makes this media form costly; therefore, dated materials are used with discretion. Fact sheets are less costly and therefore may be used to convey information that changes more frequently, such as the dates of one-time meetings (see Exhibit 5-16). If properly designed, brochures and fact sheets may be mailed in bulk, presented in display cases, and mailed in personal letters with a business card attached. Design recommendations include: 1) emphasize information answering who, what, when, where, why, and how; 2) use a logo, motto, color, or picture associated with the program or agency; 3) use action photographs; 4) give a source for further information, such as the agency's telephone number; and 5) design the brochure or fact sheet so that it can be carried in someone's pocket or placed in a regular-size file folder.

Exhibit 5-16
THERAPEUTIC RECREATION PROGRAMS
CONSUMER MEETINGS

The division is initiating city-wide leisure opportunities for persons with disabilities and is seeking input from persons interested in this effort.

Meetings will be held at recreation centers in each district of the city according to the below listed schedule. During the meetings participants will be completing a questionnaire to assist with scheduling and planning of activities.

Contact the main office for specific information: REC-PLAY.

Meeting Schedule

Center	Location	Date, Time
North Rec Center	200 Seeview Dr	Jan 15 noon
East Rec Center	300 Skyview Dr	Mar 30 7 pm
South Rec Center	400 Park Pl	June 10 10 am
West Rec Center	500 Fun Blvd	Sept 1 3 pm

Bulletin boards and displays are effective in presenting program themes, calendars, schedules, participant information, and actual samples or replicas of projects, plans, and activities. To most effectively use this media, focus on one topic, be timely and accurate, and carry out ideas in a creative manner. Materials which are to be used outdoors must be durable and not subject to fading and damage by the sun, rain, or wind. A bulletin board or display must be self-explanatory since narration is generally limited or nonexistent.

Films, slides, and videos can speak directly to the audience without interpretation from a third party and can be updated without completely re-doing the presentation. Although costly, this form of media has the advantage of combining sight, sound, drama, movement, color, and music to capture an audience's full attention. Staff must determine what it is that they want the viewers to feel or think at the end of the presentation. This becomes the goal for writing the script. The narrative should answer who, what, when, where, and how. Presentations of less than 10 or 15 minutes are most effective.

Direct mailing of agency newsletters to internal audiences and to selected external audiences allows for wide dissemination of program information. A computerized mailing list containing the addresses of social service agencies, staff, participants, contributors, and media agencies permits direct bulk mailing. Additionally, in-person delivery to key agencies allows for wider circulation and a potentially greater impact.

Newsletters serve a dual purpose: 1) to inform the general public about agency programs and services and 2) to present to participants detailed program information, such as: registration, assessment, and cancellation procedures; opening and closing dates; fees; participation policies; releases and permission statements; program descriptions; and telephone numbers to call for further information. Newsletters are generally printed quarterly and a different color is used for each season's issue. Use of a uniform format, so each department's program information is found in approximately the same place in each issue, improves readability. A logo or graphic to introduce and close the newsletter also serves to define the content.

Public Media. Public media may be friendly and timely as illustrated by a morning talk show heard on the car radio or by coverage of events on the evening news. Because a second party (the reporter or news editor) interprets the story, the agency's original intent may be lost in the translation. Public media, such as radio, TV, and newspapers, have a very large audience, therefore, by numbers alone, warrant serious consideration. One approach to aid communication between staff and public media representatives is to prepare a media file which may incorporate the following:

- List of news directors, assignment editors, talk show hosts, and public service directors working for local radio and TV stations.

- List of daily, weekly, and neighborhood newspapers; their telephone numbers, release deadlines and procedures, and the names of reporters, photographers, and editors of feature columns.

Preparation of news releases (see Exhibit 5-17) is a task which may be assigned to a staff member. Clearance must be obtained and the proper authorities within the agency must be informed before each news release is distributed. General guidelines for preparing a news release include:

1. Place the name and telephone number of an agency contact person and the desired release date at the top of the first page.

2. Double-space the text. Use two-inch margins and letter-sized paper. Type on one side only. If the news release covers more than one page, generally accepted practices are to paper clip the sheets together, type the word "more" at the bottom of each continuing page, and type the number "30" at the end.

3. The lead paragraph of the text should include pertinent data giving who did what, when, where, and why. Use no more than 30-40 words per paragraph, eliminate superlatives, spell names correctly, give accurate dates and exact titles, and assure that appropriate participant releases have been obtained.

4. Mail a copy to each appropriate outlet. Follow up at the conclusion of the event to report results and to thank the editor if coverage resulted.

Public service announcements (PSAs) (see Exhibit 5-18) usually run 10, 30, or 60 seconds in length and allow free information dissemination for nonprofit organizations but

Exhibit 5-17

FOR IMMEDIATE RELEASE
1/13/19
TERMINATE: March 19, 19__
PUBLIC INFORMATION OFFICE
Phone: 123-4567

"SPRING ART SHOW"

The Recreation Commission and the Westwood Town Hall Board of Directors will be sponsoring the "SPRING ART SHOW" on Sunday, May 1, 19 from 12 noon to 5 p.m. The art show and exhibition sale invites artists to display and sell their works at the Recreation Hall, located at West Avenue.

There will be five categories of show: Painting/Drawing, Fabrics/ Fibers, Prints/Photography, Ceramics/Sculpture and Crafts. This is a juried show and the entry in the competition must be in the category in which the artist was juried.

Awards on the day of the show will be in open competition: First Prize: $200, Second Prize: $100, Third Prize: $50 and Honorable Mention: $20. Plus, there will be purchase awards given totaling over $400.

Applications for the "SPRING ART SHOW" are available now and may be obtained at the downtown office located at Parkway. Both in-person and mail-in applications will be accepted. In-person juring will be held on Saturday, March 19__ from 10 a.m. to 12 noon. Friday, March 18 is the mail-in deadline for those individuals who are unable to attend the in-person jury session.

A $15.00 entry fee, which is refundable if not accepted is due with each application.

For more information call Marcia at "ART SHOW."

"30"

not always at the most desired times, often being aired at 6:00 a.m. or 11:00 p.m. Messages that are brief, feature a local celebrity, use "upbeat" action verbs, and seek personal support, such as the public's attendance or financial support of an event are most effective. A key to successful PSAs is to repeat essential information, such as the agency's telephone number, before, during, and/or after the narrative. For TV, use of action pictures depicting the event is effective. The length of time allowed determines the estimated number of words and visuals that may be incorporated in a PSA. Several messages should be prepared, each of a varying length, so the station can choose the one(s) which best suit their available time slot(s).

Time (in seconds)	Number of Words	Number of Visuals
10	25-35	1-2
30	60-80	2-4
60	150-160	5-8

Maintaining frequent contact with the media often gives rise to special opportunities to present detailed program information, such as by being interviewed. To assure proper presentation of the information, the interviewer should be well-informed about the therapeutic recreation program and have reviewed with the interviewee the discussion topics and airing procedures. The actual presentation should be void of jargon and in-house cliches, should be presented in a conversational manner, and should focus on the factual, rather than the sensational, nature of the program and the participants.

Exhibit 5-18

PSA
For Immediate Airing
End Date: 3/19/19__
Time: 10 seconds

Spring Art Show

The Recreation Commission announces that applications for the Spring Art Show sponsored by the Therapeutic Recreation Division are now available. The show will be held on Sunday, May 1 at Rec Hall on West Ave. For an application contact: ART-SHOW.

1/24/19__

(Continued)

(Exhibit 5-18: PSAs--Continued)

PSA
For Immediate Airing
End Date: 3/19/19__
Time: 30 seconds

Spring Art Show

The Recreation Commission invites all area artists and craftsmen to apply for the Spring Art Show sponsored by the Therapeutic Recreation Division. The show will be held on Sunday, May 1 at Rec Hall on West Ave.

Applications for this juried show may be obtained by contacting ART-SHOW. Deadline for returning application is March 25, 19__.

A $15.00 refundable application fee is due with application.

Prize money will be awarded the day of the event.

1/24/19__

Therapeutic Recreator's Responsibility to Market Services

Timely, appropriate communication must be presented ethically, that is, recognizing the intent of therapeutic recreation, the confidentiality and autonomy of the participants, and the moral responsibility of the professional. Effective marketing is essential to assure support for and credibility of quality programs, which in turn enhance community networking, thus benefiting the participants.

The therapeutic recreator may need to assume the responsibility to creatively market programs. Catchy sayings, promotional rebates, themes, logos, buttons, sunvisors, T-shirts, photo albums, slide shows, and participant performances may be among the therapeutic recreator's marketing techniques. Each technique addresses a certain objective with a defined audience. For example, a certain colored T-shirt with imprinted logo serves to identify staff, promote the program in the community, and provide participants with a quick point of reference. T-shirts may also be sold to raise funds, awarded to those with the most unique performances, given to those who first enroll in an offered program, or worn by participants to make them look and feel like a team.

Summary

The four planning tasks presented in this portion of the text establish the standard for quality programs. Operating policies and procedures are prepared in four areas:

administration, personnel, programs and resources, and participants. To prepare these, guidelines are drawn from regulatory codes, professional standards, and legal directives. These codes often appear in a staff or agency manual.

Risk management plans evolved from the need to protect persons and agencies from financial losses attributed to accidents. In therapeutic recreation, the need to be aware of safety elements in programming has intensified because more persons with greater functioning deficits are a part of the community. Written plans are incorporated into staff manuals, participant registration procedures, activity supervision, and facility management. Risk management also occurs when staff develop sensitivity to impending participant needs in relation to activity demands.

Staff assessments are used to ascertain staff skills and needs as compared to job expectations identified through job task analysis. A training and development program is designed to decrease the gap that might exist between capabilities and job demands. The five phases of such a program, orientation, pre-service, in-service, professional meetings, and supervision and evaluation, are organized to meet each staff member's needs to remain abreast of daily duties and updated as the field develops. Volunteers and part-time staff are increasingly important target audiences of such programs.

The phrase marketing of therapeutic recreation services is used to mean "communication" with various audiences in the community therapeutic recreation network. These audiences include peer staff who may be unaware of therapeutic recreation programs, or parents and caregivers who provide transportation and necessary follow-through, and administrators and persons with funding sources without whose support programs could not exist. Internal communication is through written documents such as budgets and personal contact at meetings and conferences. Marketing tools such as letters, phone calls, brochures, mailings, news releases, and audio-visual presentations are used to maintain communication with external audiences such as other human service professionals, advisory committee members, and community decision-makers. Therapeutic recreators have assumed responsibilities in this area to assure participant autonomy and integrity and program credibility in the community network.

KEY TERMS

Assertiveness training. An approach used to develop the participants' ability to express their needs in a straightforward, nonaggressive manner so that others do not manipulate their emotions or behaviors.

Behavior management. A collection of interventions used with participants to either increase the incidence of desired behaviors or decrease the incidence of undesired behaviors by controlling the consequences resulting from their displayed behaviors.

Continuing education unit (CEU). One CEU is earned by attending ten 50-60 minute sessions of approved instruction. The credit is awarded for participation in professional development activities and may be required by some professional organizations to maintain and/or upgrade professional credentials.

CTRS. Certified Therapeutic Recreation Specialist as defined in the criteria of NCTRC (National Council for Therapeutic Recreation Certification).

External audiences. A marketing term denoting persons who are either outside the agency or indirectly related to a program, such as residential and clinical staff, social workers, community recreation staff, volunteers, and the general public.

Family therapy. An approach in which the entire family engages in counseling to effect changes in their relationship which will enable each family member to better meet the needs of the other family members.

Gestalt. A term meaning "whole" and a philosophy which views people as organized wholes who must assume responsibility for their actions by becoming aware of the here and now.

Internal audiences. A marketing term denoting persons who are associated directly with a particular agency or program, such as administrators, therapeutic recreation staff, participants, caregivers, and advisory board members.

Range of motion (ROM). Exercises or activities used with participants to increase their degree of movement at the joints.

Reality orientation. An intervention approach that uses repetition in order to encourage the recall of information about the activity, the time, the day, the place, and staff and participant names. The purpose is to help the participants remain in touch with the present.

Resocialization. An intervention approach often used with reality orientation to teach or reteach skills needed by participants to adjust to the people and the expectations of their social environment.

Risk management. A leader's responsibility and written procedures to identify and reduce safety and health hazards during program delivery and participation.

Stress management. Techniques used to assist participants to gain control over their reactions to situations which threaten their security, control, and/or self-esteem.

Transactional analysis. An approach that studies verbal communication to identify how persons respond to one another. The object is to encourage openness and recognition of feelings and needs.

TRAINING EXPERIENCES AND STUDY QUESTIONS

1. Obtain operating and procedural manuals and risk management plans from a practitioner. Compare the collected materials to recommended materials in Sections A and B. What content areas are found in both the collected and the recommended materials? What changes might enhance the collected materials?

2. Interview one or more practitioners to have them identify staff training and development needs relevant to their work settings. Compare their responses to the list in

Section C. Select ten needs which appear to be the most significant and discuss their importance.

3. For either an existing program found on campus or in the community or for one developed as a class assignment, use the model in Section D to develop at least three marketing tools to share information on the program with both internal and external audiences. Design at least one tool from each media form (personal contact, controlled media, and public media).

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Management of a community therapeutic recreation program involves a variety of routine and long-range tasks as well as arrangements for special events and promotions. Left, staff and participants make ready for outdoor activities; below, the 1990 Boston winner and world record holder provides inspiration for young people in wheelchairs.

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PART V

IMPLEMENTATION

Introduction

In this phase of programming, participants attend programs and receive services. Agencies and staff cooperate to facilitate quality programming by using the most effective combination of resources. Ongoing staff training assures staff of having access to recent service trends.

A manager's ability to manage is evident in this phase of programming. As day-to-day programs are conducted, the manager must plan for short and long term growth, direction, resource utilization, and service justification. As summer programs are operated, fall and winter programs are planned. The income and expenditures of the current fiscal year are monitored while the next fiscal year's budget is developed. Networks are maintained to assure participant transitions among community services and the marketing of programs to new audiences.

An individual participant's program is designed following a process similar to that used to prepare a community therapeutic recreation program (discussed in Part III of text). Following the assessment of the participant, the leader develops the purpose, goals, and objectives statements and selects content and leadership techniques which will enable achievement of the participant objectives. Participant placement recommendations are determined by comparing program objectives with participant objectives. Participants with assessed deficits in motor areas are encouraged to enroll in programs with a focus on sensory-motor objectives; or those with social-emotional needs are referred to programs having social interaction and communication as primary objectives. Each participant's objectives are monitored during the implementation phase. Adjustments are made in the leadership techniques, the experiences, and/or the resources to better enable participants to achieve their individual objectives.

SECTION A: PROGRAM DELIVERY

An overview of the routine and long-range tasks completed by the manager and the staff as services are delivered is presented in Exhibit 6-1. The application of a systems planning approach is exemplified in this exhibit. Tasks completed during one step of service delivery enable staff to carry out the next step. The exhibit also illustrates that staff must complete routine tasks while simultaneously completing long-range tasks which enable future service delivery. The remainder of this section presents in more detail the major staff tasks to be completed as programs are being offered.

Registration

Word of mouth, seasonal brochures, newspaper articles, advisory committee or speaker's bureau presentations, referrals, PSAs, human interest stories, current program participants, and past mailing lists serve to market therapeutic recreation programs to various audiences. Participants register in person, by telephone, or by mail during established time periods preceding each session. Initial assessments may occur at this time as well as during the first few activity periods. In cooperative programs, school teachers or group home parents, for instance, may bring in the registration forms and releases as well as records indicating participant skills and needs.

Exhibit 6-1

SERVICE IMPLEMENTATION CHECKLIST

Staff Responsibilities

	Routine Tasks	Long-Range Tasks
Registration	Computer entry of participant data Phone and in-person participant interviews Conduct participant observations Conduct participant assessments Prepare daily activity plans Prepare supplies, resources	Market program offerings Attend seasonal in-services Renew network contacts Review previous evaluations Update participant documentation process Update participant files
Assessment	Collect participant data during assessment periods or initial program periods Analyze data to determine functional level relevant to skills necessary for participant success in the community	Review previous assessment data from program files and/or contact colleagues or caregivers to obtain or validate data Revise assessment tools and/or process Attend advisory committee meetings
Individual Program Plan	Write individual participant plans Recommend participant placement	Conduct programs Record participant behaviors Revise daily activity plans

(Continued)

(Exhibit 6-1: Service Implementation Checklist--Continued)

Activity Participation	Conduct activities Record participant data on individual participant programs Complete formative program evaluations	Update and revise activity plans Revise plans of supervision and risk management procedures Conduct special events
Fiscal Monitoring	Record statistics on staff/volunteer hours, participant enrollments, income and expenses per program Submit time sheets Document petty cash vouchers File mileage reports	Reconcile monthly income and expenses Update and file fiscal year projections Monitor capital projects Prepare next fiscal year budget items Maintain inventories Adjust personnel costs
Monitoring Operational Policies	Assure compliance by staff and participants with agency protocol Document communication between manager and staff and between staff and participants	Conduct staff in-services on policies/procedures Review and update policies and procedures in staff manual
Personnel Management	Conduct staff meetings Advise individual staff members Conduct staff observations and evaluations	Identify staff training opportunities Update functional job descriptions Update staff personal-professional objectives
Risk Management	Inspect site and resources Document and report risks related to participants, personnel, programs, and facilities Conduct drills and practice emergency procedures Adapt programs Reassess participant needs	Update credentials in professional skills Revise risk management manual Maintain equipment and facilities

(Continued)

(Exhibit 6-1: Service Implementation Checklist--Continued)

Market Services

- Provide staff with agency IDs
- Monitor radio, TV, and newspaper for program publicity
- Communicate by phone and letter with various audiences
- Circulate in-house therapeutic recreation newsletter
- Send "thank yous"
- Visit network contacts
- Circulate newspaper clippings file
- Conduct fundraisers
- Monitor community newsletters
- Update photo file

Registration information to require on each participant includes: home, work, and emergency telephone numbers and addresses of participants and guardians; medication and transportation consents; physician; primary and secondary disabilities; special diet or activity directives; school, workshop, or employer; photograph and media releases; insurance and risk acknowledgments; and if available or known, their participation history (see Exhibit 6-2). Complete and accurate information is critical; up-to-date telephone numbers and the names of approved pick-up persons are essential. A brochure which contains program times, participant behavior criteria, emergency and medical procedures, program structure, fee policies, participant-staff ratios, assessment and evaluation protocol, and which is distributed during registration to parents, siblings, or group home directors, transfers responsibility to comply with agency procedures to the participants and significant others.

Registration options are determined by the program structure. Participants may: sign up for classes or activities offered to persons with certain types of disabilities, such as developmental or physical disabilities; enroll by age or functional level; and/or select special events or programs, such as Holiday Crafts. To illustrate, a young adult with developmental disabilities may choose to enroll in the Tuesday/Thursday evening sports training classes, the monthly social event, and Saturday bowling with other young adults with developmental disabilities needing only minimal supervision and a staff/participant ratio of one to ten. Or, a school-aged child with cerebral palsy might select to attend the five-day-per-week after-school program offered to youth with orthopedic and neurological disabilities who require assistance with self-help skills and skill development in aquatics and motor areas with an assigned staff/participant ratio of one to five. If registrations are received in the mail, staff may review past records if the participant has been in previous programs and/or may call the registrant or caregivers to verify the accuracy of the information to determine if appropriate program selection has been made. The young adult with developmental disabilities, for instance, may be a group home resident who, after attending four sessions of the evening sports program, is determined via assessments to have social deficits. Staff may then recommend attendance in an evening creative expression program as well as the sports program to improve the level of social functioning.

Exhibit 6-2
ANNUAL INFORMATION FORM

This form is to be filled out every year in the Fall or if you are a new participant. Please fill out all applicable information completely.

MUST ACCOMPANY REGISTRATION FORM

PLEASE COMPLETE THIS FORM IN FULL AND RETURN IT TO: Northern Suburban Special Recreation Association (NSSRA):

Are you a new participant? ___ Yes ___ No
Background data: If no, please mark programs in which there has been
previous experience DLS ___ MH ___ VI ___ ECC ___
PHI ___ S&P ___ ADULT ___

Name ______________________ Sex: M F Date of birth _/_/_
First Middle Last

Parent/Guardian Name ______________________

Address ______________________
Street City Zip

Participant's address (if different) ______________________

Home Phone ___________ Work Phone ___________
Emergency Name ___________ and phone number ________ (neighbor, relative, etc.)
Doctor's Name ______________ and phone number ___________

Agency/School attending/Employer/Vocational Site ______________________
Grade ______________________
Supervisor/Teacher/Case Worker's Name ______________________

Home school district in which you reside ______________________
City District #
Education Classification (please circle) LD BD EMH TMH PHI Other ___________

Primary Disability _________ Secondary Disability ______________

(Continued)

(Exhibit 6-2: Annual Information Form--Continued)

Will the participant be receiving medication during program? Yes __ No

Drug Name ________ Dosage ________ Frequency ________ Time ________
Drug Name ________ Dosage ________ Frequency ________ Time ________
Drug Name ________ Dosage ________ Frequency ________ Time ________
Drug Name ________ Dosage ________ Frequency ________ Time ________

Medical Information: Please check the appropriate blank and identify the needed information.

	Yes	No	Describe/ Type	Occurrence date(s) or explanation
Is participant subject to seizures?				
Does participant have allergies?				
Is participant ambulatory?				
Does participant use manual or electric wheelchair?				
walking aides?				
Does participant transfer?				
or require assistance?				
Does participant have special dietary needs?				
Is participant hearing impaired?				
wears a hearing aid?				
Is participant visually impaired?				
wears glasses?				
Has had any major accidents/ injuries in past year that might affect participation?				
Does participant have or been exposed to infectious or contagious disease(s)?				
Does participant have atlantoaxial instability?				
Does participant use orthopedic or prosthetic devices?				
adapted recreation equipment?				

Please list medical recommendations and/or activities in which the participant may not participate:

____

____

____

Dates and types of inoculations: Tetanus ________

Vaccine(s) ________

Other(s) ________

(Continued)

(Exhibit 6-2: Annual Information Form--Continued)

Personal and Community Skills Yes No Explain

Participant requires and/or uses:

Assistance eating/drinking ____________________

Assistance toileting ____________________

Assistance dressing/undressing ____________________

Assistance communicating needs ____________________

Uses sign language ____________________

Assistance in ambulation ____________________

Assistance using vehicle ____________________

Assistance with reading ____________________

Assistance with writing ____________________

Assistance in orientation to people, place, time ____________________

Assistance in protecting self and anticipating safety needs ____________________

Complies with verbal requests/directions ____________________

Assistance with swimming in following skills:
- pool entry ____________________
- submerging body parts ____________________
- floating ____________________
- strokes ____________________

Does participant use:
- Life jacket or similar device ____________________
- Leader assistance ____________________
- Specialized stroke ____________________
- Adapted equipment ____________________
- Ear plugs ____________________
- Nose plugs ____________________
- Others (list) ____________________

Behavioral Needs: Yes No Explain

Participant displays or requires:

Unusual fears or concerns for:
- People ____________________
- Space ____________________
- Places ____________________
- Other (list) ____________________

Responds to specific behavioral techniques (explain) ____________________

____

Responds to specific verbal or nonverbal directions ____________________

Responds to other reinforcement devices or gimmicks like food, toy, etc. ____________________

Other information that might enhance quality and safety of recreation participation: ____________________

____

____

A procedure recommended with participants who are new to the agency's services is to require in-person enrollment and an interview with a staff member. Limited access to transportation, the presence of elderly caretakers, and registrations through a third party, such as a school system, may hamper this procedure. To illustrate, assume the youth with cerebral palsy is a new community resident so no further information is available and the youth is unable to enroll on-site. The therapeutic recreator might visit the school the youth attends in order to observe the youth among peers and to ascertain the extent of motor involvement and communication deficits. Another possible scenario could be new participants who come with registration records that do not accurately reflect either their needs or skill levels. Immediate staff follow-up is necessary. Caretakers or participants are asked to review the staff's assessments and observations of the participants in order to determine appropriate program placement. The agency's program placement policies may require that participants be reassigned to programs which better fit their functional level.

During the time period in which registrations are being accepted, program staff and managers are finalizing program preparations. For each program area, daily activity plans are prepared. Schedules and calendars are revised. Supplies are re-inventoried and ordered if necessary. Participant forms are photocopied, organized, and readied for use. Safety and security of areas and facilities are re-assessed as are participant and staff injury, illness, medication, and emergency procedures. Newly-hired staff, volunteers, part-time or seasonal staff, and full-time staff review new forms and agency protocol, develop their personal-professional objectives, study participant information, practice or learn new activity skills, update their certificates, and attend in-services on the latest trends and developments in therapeutic recreation and supportive fields. This is also an excellent time to re-examine the community to establish or renew networks, market therapeutic recreation services, explore integration options, and acknowledge community support. Although staff may psychologically view registration as "down time," the period is critical to program installation.

Assessment

From the information gathered during registration, general participant needs are identified. During the initial activity sessions, individual assessments are completed, participant objectives are written, content is selected, and leadership techniques are specified. True assessment information may not be obtainable until participants settle into the program. Participants attending programs for the first time or those who are re-entering, for example, after a summer time-lapse, require time to adjust to the new faces or changed routines.

Community settings do not offer a controlled environment in which to collect data or consistently manage participant behaviors. Assessments made during ongoing programs allow staff to use a naturalistic observation approach yet are influenced by who, where, and how data are collected. To obtain more reliable results, one staff member may be assigned to lead an activity while another staff member observes and assesses the participants during the regularly scheduled activity. In some instances it may be more desirable to delay the start of the activity and only conduct participant assessments. Another approach is to have staff individually observe the participants, then meet collectively as a team to finalize each participant's assessment and to write the individual program plans (IPPs) which contain the participant's objectives and recommended activities.

Use of standardized instruments, such as the Leisure Diagnostic Battery (LDB), Recreation Behavior Inventory (RBI), or Comprehensive Evaluation in Recreation Therapy (CERT), also enhances the assessment process. Each instrument is suited to a defined population and is intended to collect certain types of information. A therapeutic recreator might select portions of several instruments to best suit the particular situation; however, changing how the original instrument is used will affect its reported validity. Another approach is to use developmental scales, such as the Denver Developmental Screening Test or the Cain Levine Social Competency Scale, as guides for staff to design their own assessment tools.

Essential areas to assess are those affecting the participant's ability to function within the mainstream of community life. The skills and abilities necessary to function semi-independently in the community include: communication, safety, sensory discrimination, self-care, reality orientation, impulse control, skill transfer, leisure motivation, making change, telling time, traveling independently, following verbal and written directions, maintaining a minimal fitness level, functioning as a group member, making decisions, and functioning in unstructured situations.

Individual Program Plan

The individual program plan describes the objectives specific to the individual participant and gives the content and processes which will enable the individual objectives to be realized. The agency's program plans (discussed in Part III of the text) establish the framework for designing the participant's individual program plan. The content and process used to develop each type of plan are similar. To illustrate this similarity, assessment is the first step of each plan. For the agency, assessment is conducted on all community-wide resources and all potential participants. For the individual, only the individual's skills and abilities are assessed. The agency's program plan is periodically revised to consider the changing needs of the participants.

Essential sections of the individual program plan (see Exhibit 6-3) are: 1) the assessment section listing the needs, interests, and capabilities of the participant; 2) the performance objectives; 3) recommended activities and program placements; 4) leadership and management techniques; and 5) the evaluation plan. A method should also be established to record individual progress and behaviors which occur as participants attend programs. This could become section six or may be done separately (as discussed in Part VI of the text).

Exhibit 6-3

INDIVIDUAL PARTICIPANT PLAN

JONES, JILL **FILE #** **33621**

FOR OFFICE USE ONLY

NAME: Jill Jones **DATE OF ENTRY:** 6/12/19--

ADDRESS: 3122 Sycamore Terr. **SOCIAL SECURITY #:** 416-28-9999

Killen, TX 76541 **PHONE #:** (817)699-6543

IN CASE OF EMERGENCY:

1. **NAME:** M/M Robert Jones **RELATIONSHIP:** Parents

ADDRESS: 3122 Sycamore Terr. **PHONE #:** (817)699-6543

Killen, TX 76541 **WORK PHONE #:** (817)287-6739

2. **NAME:** Charlotte Webb **RELATIONSHIP:** Aunt

ADDRESS: 24-B Tank Destroyer **PHONE #:** (817)287-8949

Ft. Hood, TX 76540 **WORK PHONE #:** (817)532-1102

PERSONAL INFORMATION:

DATE OF BIRTH: 12/2/75 **SEX:** Female

OCCUPATION: Student (3rd grade) **RACE:** Caucasion

GRADE LAST COMPLETED: 2nd **MARITAL STATUS:** Single

U.S. CITIZEN: YES or NO **IF NO, WHAT NATIONALITY?**

REFERRED BY: Killeen I.S.D.

MEDICAL INFORMATION:

Jill has been profoundly deaf from birth. The cause of deafness is unknown, but believed to be the result of antibiotics administered to her mother during the first trimester of fetal development. She was diagnosed as deaf at 18 months old. She was fitted with binaural hearing aids and a tactile stimulator at two years of age.

Jill's audiogram reveals a speech reception threshold of 90 dB in the right ear and 95 dB in the left ear. Her aided SRT is 45 dB binaurally.

Jill has no additional physical or mental problems.

Exhibit 6-3 (Continued)

REASON FOR REFERRAL:

Jill was referred to the therapeutic program because of her delayed language (3-5 year delayed) and her poor reading ability. Her parents and teachers agree that she needs reinforcement throughout the summer months. Jill is currently functioning at the second grade level in language and reading while exhibiting good comprehension of third grade level mathematical concepts.

Jill also needs more social interaction with children her own age according to concerns expressed by her parents. She is an only child and has very little interaction with other children outside of the school setting. Her favorite leisure activities are those that she participates in alone. She enjoys arts and crafts, swinging, playing with her Barbie Dolls, and her dog, Fido.

	NEEDS:	**ASSETS:**
COGNITIVE	1. Expressive language growth 2. Improvement of reading comprehension	1. Good receptive language comprehension 2. Excellent problem-solving abilities 3. Creative imagination
SOCIAL	1. Initiating interaction with peers 2. Cooperation with peers 3. Sharing with peers	1. Relate well to adults 2. Eager to please others
MOTOR	1. Increase confidence in using gross motor skills needed for team games 2. Improve coordination	1. Well developed fine motor skills 2. Good coordination

Exhibit 6-3 (Continued)

LONG TERM GOAL #1: Jill will increase her ability to expand vocabulary and write sentences.

Short-term goals	Objectives	Activities	Methods (Leadership Intervention)	Evaluation
(A) Jill will use a variety of words to discuss a given topic.	Jill will: (A) Use at least 3 different words to discuss a topic each time she participates in discussions	1. Bicycling	Discuss parts of a bike, bicycle safety, and routes.	Therapist will: record words used
		2. Tour of factory	Describe what she saw at the factory afterwards.	record words used
		3. $20,000 Pyramid game	Play the game with a partner her age.	observe objective
		4. Password game	Play the game with a partner her age.	observe objective
(B) Jill will compose 3 or more simple sentences on a single subject to describe, inform, persuade, or tell a story	(B) Write at least three simple sentences on a single subject in at least 3 different situations with 80% this summer	1. Make a book	Write a story, illustrate it and bind it for others to read.	monitor progress and check finished product
		2. Write letters	Write letters to other folks in the program.	observe objective
		3. Make invitations	Plan a party (A summer birthday party) - make invitations.	monitor program read invitation for objective
		4. Gardening	Keep a log on the changes occurring in a garden spot.	check log for objective

Exhibit 6-3 (Contianued)

LONG TERM GOAL #2: Jill will increase her understanding of herself and her environment.

Short-term goals	Objectives	Activities	Methods (Leadership Intervention)	Evaluation
(A) Jill will state likes and dislikes and explain	Jill will: (A) State her likes and dislikes in relation to at least 3 activities and explain her feelings 90% of the time	1. Fishing	Ask Jill to tell what she likes or dislikes about fishing.	Therapist will: observe objective
		2. Croquet, etc.	Ask her to make a chart of activities she likes/dislikes.	check chart for objective
		3. Captioned movies	After the movie, ask Jill what part she liked/disliked in it.	observe objective
		4. Video Games	At a video arcade, Jill can choose to play the game she likes. Explain why.	observe objective
(B) Jill will compare herself with others	(B) Compare herself with others by identifying likenesses and differences in at least 3 separate activities	1. Photography	Take pictures of peers. Group according to likenesses/differences.	Check groupings for objective
		2. Skating (Roller)	Notice who can/can't skate, backwards, turn around, etc.	observe objective
		3. Piñata	Learn about Mexican customs. Make a paper piñata product.	observe objective and check finished product
		4. Fortune Cookies	Compare self to Chinese child. Make fortune cookies. Write fortunes.	observe objective and check finished product
(C) Jill will take responsibility of deciding what to do in conflicts	(C) Solve her own conflicts in at least 3 situations documented by therapist	1. Playground	Observe Jill during unstructured play time. Document problem-solving.	observe and document objective
		2. Role play	Give each client a hypothetical conflict to solve. Group discussion.	observe and document objective
		3. Camping	Weekend camping trip. Watch for opportunities for conflict.	observe and document objective
		4. Sandbox	Unstructured play time for Jill and peers. Document conflict.	observe and document objective

Exhibit 6-3 (Continued)

COMMENTS:

Jill will participate in the summer therapeutic recreational program to improve cognitive and social skills predominantly. She will be enrolled from June 17 through August 23. A meeting with Jill, her parents, teachers, and summer recreation staff is tentatively scheduled for 6:00 p.m., August 23, at the recreation center. At that time, we will discuss Jill's progress in the program and the need for either a transitional program or her discharge from the program. When school has resumed, Jill could continue with the program at the recreation center in the afternoons or staff members could collaborate with her classroom teachers to help them create a beneficial therapeutic environment in the school setting.

Jill's parents have exhibited an enthusiastic willingness to cooperate in any way for Jill's benefit. They suggested that they might be able to help Jill at home by encouraging her to invite friends over at least once a week. They have also agreed to read a storybook to her every night, giving her more exposure to stories and print. Jill's mother showed some reluctance toward the idea of giving Jill much freedom in the kitchen for safety reasons. It was decided that she would set the guidelines, but still allow Jill to make mistakes so that she can use problem-solving techniques to achieve her desired results.

Behavior modification is not expected to be necessary with Jill. It was suggested that Jill would probably perceive "time-out" as a reward since she enjoys time alone. Jill's parents and teachers agreed that she responds beautifully to positive reinforcement. She will need much encouragement to include others in her play, but is expected to gradually develop friendships within her peer group.

The assessment information gathered and recorded in section one is used in section two to write the performance objectives. The child with cerebral palsy needs services defined as therapeutic recreation while the young adult with developmental disabilities needs services defined as recreation participation. The objectives of their respective individual program plans would be written using the objectives from the agency's program plans for therapeutic recreation or for recreation participation as a guide.

To develop section three, staff review existing program plans. Specific activities within the content areas are selected to enable as many participants as possible within the group to realize their individual objectives. The child with cerebral palsy needs motor skill development, practice with self-help skills, and activities to relax muscle groups. Staff recommendations would include activities which help to develop fundamental motor skills, such as rolling, grasping-releasing, pushing-pulling, bending-extending, stretching-relaxing, walking, moving to rhythm, marching, climbing, swimming, riding a training bicycle, playing in sand, throwing at targets, and hiking. The activities found in an after-school gym-swim program would be appropriate to include in this child's individual program plan because they meet the needs to improve fundamental motor skills, dressing skills, and relaxation of contracted muscle groups. To accommodate the young adult with developmental disabilities, activities selected from a sports program would satisfy the participant's assessed needs. Therefore, individual performance objectives would be written using the objectives from the agency's sports program as a guide and the young adult would be placed in appropriate activities, such as low-organized sports and games.

The leadership and management techniques of section four are determined following the selection of activities and participant placements. Leadership techniques appropriate to specific groups of individuals were presented in Part III of the text. On each individual program plan, staff write specific, recommended management techniques, such as behavior management, and specify interaction techniques to use with each participant. Additional generic leadership techniques are presented in the following paragraphs under the heading Participation.

Section five contains the criteria for evaluating participant success in the program. These criteria are used when the participant either completes a session or departs from the program. Staff review the individual program plan to determine if objectives have been achieved and to record pertinent data about the participant's behavior during the program. Use of this information enables the staff to recommend that the participant transition to programs requiring an increase or decrease in skill level, to new programs, and/or to integrated programs in other agencies.

Participation

Class size, the frequency of class meetings, and staff/participant ratios are predetermined by the agency's philosophy and program structure. Participants may either rotate as a group through a similar schedule or follow an individualized program.

Likewise, staff may be assigned to either stay with a particular group of participants or stay with a specific program. Services entitled "therapeutic recreation" are more frequently offered to smaller groups of lower functioning participants and more staff is assigned to each group. Wheelchair sports programs generally service higher functioning participants. Such "recreation participation" programs require less structure, are generally offered weekly to larger groups of participants, and are supervised by fewer leaders and volunteers.

From the purpose, goals, and objectives of each program area (therapeutic recreation, leisure education, and recreation participation), daily activity plans are designed. Each activity plan (see Exhibit 6-4) includes activity objectives, the resources needed, step-by-step leadership techniques, modifications, the content sequence, time requirements, alternative activities, and management suggestions. The actual number of activity plans prepared is influenced by the participant's current functional level and the service intent. With lower functioning participants, progress is measured at smaller intervals; thus, one activity plan may be repeated several times using modifications of the primary motor activity to reach one objective. For a higher functioning participant the intent may be to maintain previously developed skills while improving other skills. Thus one activity plan may be repeated using activity variations and when improvement is noted, a new activity plan is introduced.

A plan of supervision or activity protocol sets the routine to be followed during each period or event. Whether the period lasts one-half hour, all evening, or one full day, standard staff responsibilities are to: 1) organize the group; 2) introduce the activity; 3) set participant parameters; 4) conduct and monitor the activity; and 5) debrief participants. To actually conduct the activity, the leader must: demonstrate the activity, allow participants to clarify activity directions, conduct the activity, and conclude the activity when the participants' interest has peaked. These steps may be modified to take into consideration the participants' need to overlearn certain skills and to assure a safe environment by considering medical or health-related needs. According to the plan of supervision, it is the leader's responsibility to make sure that the area, supplies, equipment, and activity are safe and ready for use and that the participant is capable of performing the required skills.

Transition between activity sessions, and among the activities within a session, is very important and must be well-organized. Participants acquire skills by participating in well-planned transitions. Structure and routine assure minimal loss of time. Travel time should be regarded as part of the activity time whether the participants are traveling in a bus to an outing or whether they are walking from one area of the room or the building to another. Also, during integrated experiences, it is more appropriate to have a few participants and staff, rather than a large group, walking and sitting together, such as at a theater or sporting event.

Monitoring of participant behaviors while activities are being conducted is critical. "Having eyes in the back of your head" aptly describes the leader's role. Seeing the whole while focusing on the performance of a few enables staff to anticipate environmental

Exhibit 6-4
ACTIVITY PLANNING SHEET

Program Number/Site: __________ Date: __________ Session #: __________

Goals Numbers: __________ Objective Numbers: __________

Resources (list needs):

Facility/Area __________

Equipment __________

Budget __________

Safety precautions & procedures: __________

Time	Activity Sequence	Leadership Responsibilities

Adaptations/Modifications: __________

Contingency Plans: __________

influences on participant behaviors. A sudden noise, the misbehavior of one participant, dropping a prop, or accidental misuse of a piece of equipment may trigger a chain reaction among participants. Likewise, excitement, a more-demanding-than-usual exercise routine, a new setting, or a delayed reaction to a frustrating ride to the activity center may precipitate a seizure or an emotional outburst, thus requiring staff to reorganize the activity to protect all participants.

Allowing participants a few moments to debrief before the next activity or before departure for the day encourages them to regain composure and allows time for the staff to assess the health and safety of participants, staff, and resources. For instance, with participants who have physical disabilities, staff should observe the condition of the braces or wheelchair and any heightened spasticity. While observing the participant, the leader can ask how the activity was liked or if the equipment has been returned to its proper place.

SECTION B: MANAGEMENT TASKS

Fiscal Management

The task of fiscal management entails more than accurate record-keeping of income and expenditures. The manager must also maintain statistics on: 1) the number of staff hours in direct and indirect service functions; 2) volunteer hours; 3) the number of persons served in various programs and in indirect services, such as leisure referrals or transitions to other agencies; 4) the number of services offered and the cost per participant per service; 5) time cards; 6) petty cash and mileage records; 7) merit and cost of living increases; 8) fluctuations in agency costs for staff salaries due to staff leaving or being hired; 9) the allocation of monies from fees, charges, donations, or grants; 10) the monetary value of donations, in-kind services, and indirect services; and 11) other expenditures, such as for utilities, office supplies, publicity, recreation supplies, and miscellaneous supplies and services. Monthly accounting reports give income and expenditures by coded categories (see Exhibit 6-5). The manager's responsibility is to either maintain a running account of amounts received and expended in each account code or reconcile the therapeutic recreation department's accounting sheets with the master budget. These responsibilities vary with the size of the agency.

Monthly, quarterly, and/or pay period accounting reports are essential as they indicate income and expenditure pattern changes, encumbered and unencumbered funds, and the balance remaining in each account code. From these the manager projects year-end figures for each service or program. To illustrate, the manager reviews staff and program time cards (see Exhibit 6-6) to determine salary monies and the direct and indirect program costs which are charged against the various therapeutic recreation account codes. The manager uses this information to take the immediate corrective measures necessary to balance the budget. Information necessary to prepare financial reports is also gathered and submitted by the manager to the appropriate supervisor.

Using previous monthly income and expenditure records, the manager recommends the budget for the new fiscal year to the appropriate supervisor and/or committees. The final budget may or may not be approved exactly as the manager had recommended. When the new budget is received by the manager, the manager studies the monies allotted to each account code. During each month the manager records income and expenditures by account code. At year's end some accounts may be over spent or others under spent. The total expenditures for all accounts should be within the total amount allotted for the year. To illustrate, some accounts may be over spent because of major equipment failure, such as at the waterfront. Other accounts may be under spent because of staff turn-overs, such as the hiring of a less experienced person to replace a more experienced person. Personnel costs comprise 60 to 85 percent of the total budget.

Public agencies usually credit monies received to the general fund. Private, nonprofit agencies generally have more control as to how revenues are distributed. Advisory committees of either public or private nonprofit agencies may apply for 501(c)(3) tax exempt status in order to receive major donations. These funds are often used for special events, such as Special Olympics and holiday events.

The actual management of funds is time consuming. Who is assigned to monitor the monies within the department is influenced by staffing patterns. With part-time and seasonal employees or volunteers comprising the bulk of a department's staff, budgeting probably remains with the manager. When the department has many full-time staff, the manager may assign some of them to monitor particular account codes.

Budget preparation is a year-round process commencing with the writing of staff and program goals and objectives and the adoption of the budget by a board or council. Periodically throughout the year specific forms are due on capital, committed costs, replacement costs, and expenditures by worker years (one worker year is equivalent to 2,080 hours). Therapeutic recreation staff must prepare documents on time and be capable of interpreting the budget process to their advocates. Difficulty with budgeting arises when staff are not familiar with the proper forms to use or procedures for filing a request or submitting a form; therefore, budgeting is always an appropriate in-service topic.

Preparation of the budget is made easier by keeping up-to-date records of monies in each account code and by keeping year-to-year records so comparisons may be made. It is essential to keep inventories so replacement costs can be projected. Previous time cards and mileage reports also provide data on when staffing costs or travel expenses fluctuate. By keeping accurate attendance records, the cost per participant is more easily determined. Accurate documentation of volunteer and staff hours reveals true personnel costs per program. A file folder containing product catalogues from a variety of companies encourages competitive purchasing.

Exhibit 6-5

Worksheet

JUNE 30, 19-- BUDGET BALANCES REPORT
BUDGET VARIANCE REPORT DUE JULY 25, 19--

ORGANIZATION	NAME	CODE	EXPENDITURES (OVER)/UNDER YEAR-TO-DATE ALLOCATION	% OF VARIANCE RELATIAVE TO LINE ITEM BUDGET
DISTRICT 1	Gas & Electric	7240	$30,390.50	14.35
	Other Services	7200	($ 4,848.81)	-15.28
	Commodities	7300	($ 7,927.62)	-40.28
DISTRICT 2	Gas & Electric	7240	($33,938.46)	-17.10
	Other Services	7200	($ 4,438.06)	-11.67
	Commodities	7300	($ 6,085.08)	-30.14
DISTRICT 3	Other Services	7200	$ 3,953.59	9.51
	Commodities	7300	$ 2,981.41	11.33
AIRPORT PLAYFIELD	Personal Services	7100	($18,072.80)	-50.81
	Other Services	7200	$ 1,864.94	21.19
SENIORS	Gas & Electric	7240	$12,330.37	22.42
	Other Services	7200	($ 2,085.76)	-12.49
	Commodities	7300	($ 1,167.57)	-14.07
ATHLETICS	Youth Officials	7289	($ 2,800.00)	-23.73
THERAPEUTICS	Commodities	7300	$ 2,836.04	39.66
MAINTENANCE	Other Cont. Serv.	7200	($ 6,930.76)	-15.03
	Sodium Hypochlorite	7354	$ 8.300.20	16.60
	Other Commodities	7300	$15,269.64	8.06
WATERFRONT	Gas & Electric	7240	($ 2,448.43)	-6.12
	Other Services	7200	($ 2,662.10)	-10.24
	Commodities	7300	$ 3,586.84	23.64

Exhibit 6-6

DIVISION OF THERAPEUTIC RECREATION

Time Cards

Please complete the following information for each program worked:

		This should include time prior to program, dressing time, evaluation time, and time to set up and take down equipment.			Time other than actual program time—be specific as to what work was performed and for what specific program, paperwork, training, phone calls, etc.
Date	Program	From	To	Total	
6/15	Adventure	8:30	3:00	6.5 hours	3:00-3:30 .5 hr. call parents

Policies and Procedures

A manager is ultimately held accountable for department policies and procedures. The manager is a role model and must objectively, consistently interpret policies and procedures to all staff. While the program is operating, the manager is often called upon to instantly interpret written program, participant, staff, and administrative policies.

Administrative policies that require monitoring are those concerned with following the chain of command, communication with internal and external audiences, and general agency protocol. Staff must be knowledgeable of the process to follow when requesting policy changes. A manager must avoid overuse of either "because I said so" or "that's the policy." A more appropriate statement would be: "The interpretation of the operating policy is that staff must notify their supervisor in writing before scheduling an appointment with another person of equal or higher rank."

Personnel policies are critical as most of them impact service delivery. Staff tend to be familiar with those having a bearing on their paychecks. Staff must be advised to become familiar with each policy because violations not only are detrimental to the program but also make the employee subject to reprimand. Special reminders may be needed about specific participant policies, such as confidentiality, communication with caregivers, or health and safety procedures.

Caregivers may ask staff to break written policy by requesting to register late or to register their preschool child with multiple disabilities in a summer program designed for school-aged children so they won't have to hire a sitter. Likewise, when staff forget to secure the equipment room or neglect to report the presence of a news reporter, policies are violated, even if not intentionally. When staff do violate a policy, the manager must give the situation immediate attention by sending them a "letter of understanding" or a "letter of interpretation" that clarifies the interpretation of the affected policy.

Policies pertaining to participants are most often derived from actual experiences occurring during the delivery of therapeutic recreation programs rather than from the personnel division or the agency's code of conduct. When emergencies arise, such as a participant having a seizure in the pool or a camper being lost, adherence to established procedures is critical. By role-playing participant incidences during in-services, the staff is encouraged to respond properly to actual situations. Seeking staff assistance in the development or rewriting of policies encourages their compliance and cooperation in following the policies.

Personnel Management

The effectiveness of a program is dependent upon the individual helper skills of staff and their ability to function as a team. Communication is at the heart of being a successful helper, team member, and personnel manager. What is said is often not as crucial as how, where, and by whom it is said. To communicate is to inform. Staff should receive the proper amounts of information at the proper times and places. The manager and the staff should have a clear understanding of their respective job descriptions, the staff retention and evaluation process, and the staff training and development program in order to assure job satisfaction and a positive morale. Communication is also enhanced when staff know each others' personal preferences and interests. Staff respond best when there is strong leadership and when expectations of them are clearly presented.

Knowledge of one's own management style aids the manager to anticipate the staff's reactions to management directives. Regardless of whether the manager manages by example, by democracy, or by power, the most essential skill is to be direct and to cite specific examples to clarify what is meant. In personnel matters, staff have the same right to respect and confidentiality as do participants.

A functional job description establishes work expectations; the evaluation process outlines the criteria used to evaluate satisfactory completion of job tasks; and the retention and promotion process rewards those fulfilling or surpassing the work expectations. With the staff writing and revising their personal-professional objectives each year, staff are given the responsibility to properly manage themselves as employees. To constructively guide the staff to write meaningful and appropriate objectives requires the manager to possess counselor or helper traits, such as confrontation, clarification, silence, rephrasing, and valuing.

Staff training and development is a manager and agency commitment which fosters the personal-professional growth of the staff and the expansion of the program. From written staff objectives, personal staff inventories, and observation of the staff during programs, a manager becomes aware of those skills needed to advance the staff member as a person and as a professional while enhancing delivered services. Staff training may occur during the time when seasonal program changes are being made and as a substitute to regular staff meetings. Holding the training off-site and adding special features, such as a speaker or a meal, conveys the message to staff that they are important. Also, allowing time to practice what they have heard, seen, or learned encourages them to use their newly acquired skills with the participants.

Two areas requiring a manager's attention are staff time management and burnout. Staff time management and avoidance of staff burnout may well be the most common headaches of an administrator. How to establish short and long term goals, follow a schedule, and not procrastinate in the completion of routine tasks, such as paperwork, are essential skills for all staff. The use of hour-by-hour calendars to report their activities helps staff become aware of how they do and don't use their time. Misuse of time may be an indicator of impending burnout.

Burnout, as well as being harmful to the mental health of staff members, hinders their effectiveness as a helper and a team member. A manager realizes that extra effort is needed to provide staff with relief and to change conditions if the work environment contributes to staff burnout. Lack of sufficient monetary reinforcement, a high number of participants, or participants who have shown little growth over time contribute to staff frustration. A manager who supervises from the feet rather than the seat is in a position to refocus, encourage, and supplement staff efforts. To illustrate, the manager who observes excessive amounts of time being used in routine tasks is cognizant that this could be a sign of staff having reached their limits. Further investigation might suggest that such environmental factors as a large number of lower functioning participants or a limited supply of age-appropriate equipment is contributing to staff frustration. This observation should trigger concern and appropriate action on behalf of both the staff member and the participant as neither are likely to be having a positive experience.

Risk Management

While the program is being conducted, staff must assure safety and quality control. A manager must instill in staff a sense of responsibility to themselves, to the participants, and to the program to avoid any situation or condition which would place any of them at risk. All staff members must feel obligated to follow established safety procedures during their leadership. They must accurately assess the participants' abilities and adapt programs to meet the participants' needs.

Safer programs result when staff assist the manager in developing a risk management plan, conduct routine inspections, and regularly report their risk management concerns (see Exhibit 6-7). Agencies also attempt to control risk factors by requiring such credentials as lifesaving, CPR, and first aid. Unfortunately, a good time to re-emphasize safety procedures is after an injury or accident.

Assigning each staff member to be the risk manager for a month, during which time they would also be responsible to hold drills and mock incidents, is another technique to generate awareness and interest in this area. Staff must also know how to reach support persons, such as a plumber or electrician. A list of these persons and brief instructions should be placed near the telephones to allow quick access to their services. Maintaining a good relationship with the maintenance crew pays off when equipment needs minor repair.

Marketing

During program operation, marketing efforts intensify. The manager needs to monitor daily newspapers, committee meetings, the annual reports of other service organizations, as well as participant and staff behaviors. The manager and staff must maintain poise and control when addressing various audiences. Staff must separate personal from professional viewpoints. The task of interpreting therapeutic recreation is ever present.

Daily reading of local and regional newspapers and listening to influential talk shows helps the staff to understand the forces which influence their programs and to develop a sense of community. Maintaining a file of newspaper clippings to circulate among staff keeps everyone updated. Individual staff members may also be assigned to monitor other social service and recreation programs in the community. Agencies may print a newsletter that includes their schedules as well as advocacy information and integration opportunities.

A slide show, photo album, or scrapbook approach is effective in marketing individual programs to both internal and external audiences. An agency logo worn by staff and participants publicizes the therapeutic recreation program. Field trips and fundraising efforts also tend to attract the public's attention and thus help the networking process. Consistent communication with media outlets encourages continuous coverage. A

Exhibit 6-7
RISK MANAGEMENT POLICY

It is the purpose of NSSRA (Northern Suburban Special Recreation Association) to provide safe, quality services to eligible participants at the most professional level possible. To this end, a program that guides the delivery of safe quality services will be implemented and monitored.

This program will be implemented by applying the following processes:

1. The use of sound therapeutic recreation management and quality control procedures.
2. The systematic and continuous identification of experiences that contribute to risk during administration and program delivery.
3. The ongoing review, evaluation, and documentation of personnel, services, and resources to assure compliance with quality control procedures.
4. The retention and supervision of qualified leaders to deliver services in accordance with the best professional practices and most reasonable standard of care.
5. The delivery of systematically designed and evaluated programs and services that comply with professional standards and reflect the most recent professional developments and trends.
6. The use of resources that have been properly maintained, inspected, and adapted to participants' functioning abilities.
7. The provision of routine employee development and training programs that support management of quality control procedures.
8. The ongoing management and evaluation of a public relations program to assure continuous, accurate communication; information dissemination; and awareness of safe quality services among staff, participants, caregivers, peer professionals, volunteers, and the general public.
9. The retention of self-funding of risk and legal counsel consistent with NSSRA's financial resources and statutory obligations.

This program will be monitored by applying the following processes:

Employees: It shall be each employee's responsibility to be aware of their delivery setting in order to note conditions or services in which control and safety are lacking. These situations shall be documented and reported to their immediate supervisor for action and follow-up.

Supervisors: It shall be each supervisor's responsibility to implement and monitor quality control measures by 1) motivating employees to perform competently and carryout NSSRA's quality control measures, 2) submitting reports to the oversite manager/committee, and 3) taking follow-up actions to assure compliance with NSSRA's quality control measures.

Oversite Manager/Committee: The quality control manager/committee shall oversee the implementation, monitoring, and evaluation of NSSRA's quality control program by 1) periodically and annually reviewing and revising appropriate standards, and 2) recommending appropriate policies and procedures to the executive director for board approval.

Executive Director: It shall be the responsibility of the NSSRA executive director to annually inform the board of directors of the evaluation of the quality control program for its disposition and action.

Board of Directors: It shall be the responsibility of the NSSRA board of directors to annually act upon the employee and management recommendations to the quality control program.

(Continued)

(Exhibit 6-7--Continued)

QUALITY CONTROL MONITORING POLICY

I. Employee Responsibilities
  - A. Each employee must comply with the employee operating procedures at each program site.
  - B. Unsafe conditions and/or acts must be reported to your immediate supervisor.
  - C. All accidents, with or without injury, must be reported in writing to your immediate supervisor.
  - D. Each employee must keep their immediate work and program areas safe and identify any potential risk situations.
  - E. Each employee is responsible for updating their employee file to include current certificates and in-service training records.
  - F. Each employee is responsible for informing their participants of the rules/regulations and safety requirements at each program site.
  - G. Each employee is responsible for updating and maintaining program and participant files, reporting participant needs, skills, and progress, and participation outcomes.

II. Supervisor Responsibilities
  - A. Motivate the employees to carry out the quality control program by thorough instructions and example.
  - B. Review operations and written reports to assure that the programs/services are being delivered according to quality control procedures.
  - C. Perform inspections of facilities/equipment/vehicles and report results to risk manager or committee.
  - D. Assure that follow-up action is taken when employee reports so warrant.
  - E. Report unresolved risk situations and prepare summary of quality control reports for regular review by oversite manager/committee.
  - F. Ensure that each employee's file is updated to include supervisory and performance records.
  - G. Review program and participant files to assure appropriate staff recommendations on participant needs, skills, progress, participation outcomes, and program placement.

III. Oversite Manager/Committee Responsibilities
  - A. Represent NSSRA in quality control issues and trainings, communicate on safety matters with member park districts, and promote within NSSRA the delivery of quality safe programs/services.
  - B. Prepare annual report and make recommendations to executive director/board of directors on implementation/monitoring/evaluation of quality control program.
  - C. Provide training for employees/volunteers of NSSRA and member districts on quality control issues.
  - D. Assist supervisors in review of employee reports and recommendations for follow-up action.
  - E. Arrange regular meetings to receive, monitor, and evaluate quality control reports and actions.
  - F. Ensure that areas/facilities/equipment/vehicles comply with operating codes/standards.

(Continued)

(Exhibit 6-7--Continued)

IV. Executive Director's Responsibilities
  A. Supervise and promote NSSRA implementation of quality control procedures.
  B. Submit an annual report to the board of directors with evaluation of and recommendations for revision of the quality control program.
  C. Review reports and records submitted to the oversite manager/committee and take appropriate follow-up action.
  D. Recommend and support training programs and resources on quality control matters.
  E. Develop policies, procedures, and personnel criteria supportive of the best professional practices and most reasonable standard of care.

V. Board of Directors Responsibilities
  A. Review and take necessary action on executive director recommendations.
  B. Articulate member park district safety management procedures and training opportunities.

therapeutic recreation department newsletter, sent at regular intervals to agency administrators and selected external agencies, keeps the program visible. Without support from volunteers, taxi drivers, or community leaders, therapeutic recreation programs would be more limited. Thank yous said often and in as many ways as possible are sound public relations. Staff must be constantly reminded that every letter on official letterhead or every telephone call communicates something representative of the agency or program. The receptionists and janitors must answer the telephone just as well as the manager would. Adequate marketing tells the story as it should be told. Each staff member, in essence, is a marketer or advocate of therapeutic recreation.

Summary

A program is the visible product of a therapeutic recreation department — the department is judged by what it delivers. From the moment registration commences until the last newspaper item appears, the program and the manager's abilities are on display. This phase of programming converts thoughts into actions. During implementation the manager's ability to make decisions and to take follow-up action is tested. Each aspect of the program must mesh. While the daily, weekly, and monthly implementation of programs occurs, the next budget and new programs must be planned.

A manager must assure that each participant's individual program plan is reflective of the information gathered during the community and agency assessments. Offered activities must be congruent with IPPs. Leaders must facilitate participant growth toward IPP objectives through the activities chosen to be conducted.

A manager spends large quantities of time monitoring fiscal and personnel matters. Paying attention to details while not losing sight of the total impact is an essential skill. Acknowledging staff dedication and job commitment with timely recognition fosters their interest and concern for risk management and adherence to policies. Honest, targeted release of information to keep parents, staff, and supporters abreast of program happenings garners the advocacy needed to maintain therapeutic recreation services.

KEY TERMS

Clarification. A verbal skill used with staff and participants to better explain meanings.

Confrontation. A verbal skill used with staff and participants to bring issues or concerns forward for consideration or reconsideration.

Daily activity plan. The staff-developed written document outlining the objectives, resources, content, and process of each scheduled activity session.

Encumbered. Monies in the budget which have been expended for a product or service but for which outright payment has not yet been made.

501(c)(3) status. The tax-exempt status given to a nonprofit organization by the Internal Revenue Service.

Individual Program Plan. The staff-developed written document outlining a participant's leisure objectives, recommended experiences, and criteria to evaluate participation.

Plan of supervision or activity protocol. A risk management document specifying the recommended procedures which are to be used to conduct participant activities.

Rephrasing. A verbal skill used with staff and participants to restate a thought or concept to allow for further consideration.

Silence. A skill used with staff and participants in which time is allowed for contemplation of issues or ideas.

Unencumbered. Monies in the budget which are available to be spent.

Valuing. A verbal skill used with staff and participants in order to identify the significance of an interest, skill, or belief.

TRAINING EXPERIENCES AND STUDY QUESTIONS

1. Study newspapers and magazines to collect programming ideas and resources. What programs could be developed using the information gained from this review?

2. Gather and review blank application and registration forms. Consult with a computer programmer to design a form appropriate for collecting participant data and which also allows entry of information into a computerized participant file.

3. Identify several forms of media used to market programs and services on a continuous basis to participants and caregivers. What techniques and qualities seem most successful in encouraging participants to register session after session?

4. Maintain an hour-by-hour listing of your activities. Identify those activities that

were preplanned and those that were unanticipated. What factors contribute to unexpected activities? Which activities must be done and which should be done? Could your day be organized in a more efficient manner? If so, how?

5. Collect various budget forms. How is the use of each related to the entire budget process? For a particular program, determine which costs are direct and which are indirect. Explain the difference.

6. For a particular program, such as aquatics or crafts, review appropriate catalogues and determine the cost of purchasing the supplies which would be needed.

7. Design a procedural manual for a community therapeutic recreation program.

8. Using a self-made form, inventory a recreation facility to identify potential risks. Design procedures to manage each identified risk.

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Historically, program evaluation was often limited to the number of participants per activity, and data were collected without applying results to improvement of service. Assessment should be a continuous and custom-tailored process that can contribute immediate feedback to revise ongoing programs and overall feedback that allows decisions to be made about a program's value and effect on participants.

PART VI

EVALUATION

Introduction

Evaluation is often discussed but infrequently done. Activities are inherently neutral; their effectiveness is dependent upon the ability of the leader to establish a helping relationship with the participant, to plan the most appropriate experiences, and to deliver the service in a setting suited to the participant using the resources available. Traditionally, most programs have been evaluated subjectively rather than objectively; that is, success has been measured by instinctive feelings that a participant appears to be "having a good time." Evaluation has been limited due to the often short-term nature of the experience, the lack of objectively developed instruments, the lack of financial support, the diversity of participant functional levels within one setting, the participant's voluntary program attendance, the focus on group rather than individual experiences, and the logistical problems of data collection.

Evaluation is used with assessment (discussed in Part I of the text) to establish a means to determine the worth of selected activities and the leadership techniques which will best achieve participant and program objectives. Evaluation enables accountability and measurement of effectiveness. Evaluation is the process of collecting information in order to make a judgment on how to improve service delivery. Data are used to: contribute to staff effectiveness as facilitators or "helpers"; ascertain program effectiveness in meeting participant objectives; gauge adherence to health and safety standards; monitor costs; modify activities, leadership, and resources; ensure efficient management; and secure information used in participant, program, and professional research and development.

Historically, evaluation of community therapeutic recreation programs has encountered the following limitations:

1. Measurement has been limited to the number of activities per participant and the number of participants per activity rather than the quality of the individual experience.
2. Data collection has been limited to evaluation of the end result rather than evaluation as the program is being conducted.
3. Results have been compared to pre-established professional and group standards rather than to individual developmental or functional growth criteria.
4. Standardized instruments, or sections thereof, have been used without regard for the needs (objectives) of the individual participants rather than designing evaluation tools to measure the intent (objectives) of specific programs.
5. Data have been collected without applying the results to improve programs or services, that is, data are collected and filed, never to be used again.

A comprehensive evaluation plan uses two types of evaluations during the four phases of program development. Formative (or process) evaluation occurs during the assessment, planning, and implementation phases while summative (or product) evaluation occurs during the evaluation phase. Formative evaluation is ongoing and is intended to collect data which enable the therapeutic recreator to adjust the program as it is being operated in order to achieve the desired objectives using the available resources, activities, and leadership techniques. Summative evaluation uses the information from the formative evaluation as well as data collected when the experience is completed to ascertain the effectiveness or success of a program.

Formative evaluation contributes immediate feedback and allows revisions to be made to a program while it is ongoing. Tools used to gain formative evaluation data include daily notes on participant performances, weekly or monthly program reports, activity evaluations, and ongoing staff appraisals. Formative evaluation fosters dynamic and flexible service delivery.

Summative evaluation contributes overall feedback and allows decisions to be made about a program's value. Tools used to gain summative evaluation data include overall program and participant progress reports, parent and staff critiques, and administrative reports prepared after either a program or a participant's involvement in a program comes to a natural end following a certain time period or after a desired performance level is achieved, thereby making it advantageous for the participant to transition to another program. Summative evaluation results in changes in any or all phases of the participant's and/or the agency's therapeutic recreation program. Summative evaluation establishes recommendations for further participant involvement and referral, integration, or transfer to needed services.

This portion of the text presents both formative and summative evaluation information. The evaluation process is described as it is incorporated into each phase of program development (assessment, planning, implementation, and evaluation). Material is presented in the sequence a manager would use it to: 1) prepare the evaluation plan; 2) collect formative data and adjust services; 3) collect summative data and revise services; 4) transition participants to appropriate services; and 5) prepare and present the final evaluation report.

Evaluation Plan

Prior to implementing a program, an evaluation plan must be developed. The steps to preparing an evaluation plan are: 1) selecting and preparing the data gathering instruments for each phase (assessment, planning, implementation, and evaluation) of the program plan; 2) training staff to oversee the evaluation process; 3) establishing a timetable for the collection of both formative and summative data; and 4) determining procedures for the revision of the program following formative and summative data collection.

Instrument Selection. The tools which are selected or prepared to gather data during each phase of program planning must meet the criteria of validity, reliability, objectivity, and usability (appropriateness). Few instruments exist in therapeutic recreation which satisfy these criteria and, at the same time, suit the needs of each particular community therapeutic recreation program. Staff may choose to use one portion of an instrument, such as the "Playfulness" scale from the Leisure Diagnostic Battery, to measure certain program aspects. Or they may combine useful portions of ready-made instruments with staff-prepared instruments. The staff must keep in mind the purpose for which the instrument is to be used when either selecting or preparing measurement devices. Staff must be familiar with the following meanings of each of the following four criteria:

1. Validity. Does the tool measure what it is supposed to measure? Does the tool measure the objectives the program is attempting to accomplish? There are several types of validity: predictive, concurrent, content, and construct. Predictive validity refers to the ability of an instrument to predict a behavior; for example, a high score on a fundamental motor test should indicate that a participant can successfully complete a basic obstacle course. Concurrent validity refers to obtaining like results from two instruments that measure the same concept or portions of the same concept. To illustrate, administration of the LAB (Leisure Activities Blank) (see Appendix A) and the Mirenda Leisure Interest Finder should result in essentially the same likes being selected for a particular category, such as sports. Content validity assumes that an instrument reflects the concept being measured and does so in the proper proportion. For example, with a staff appraisal form, if the assumption is made that specific helper skills are more critical than others, the number of questions in each area should reflect this weighting. Construct validity refers to the definition of the concept being measured; that is, does a leisure attitude scale properly measure the constructs defined in the concepts of "leisure" and "attitude"?

2. Reliability. A reliable instrument is one that, with repeated administrations, continues to present the same results; in other words, a reliable instrument gives constant values. An instrument can be reliable with or without being valid. An instrument may consistently measure the wrong concept; therefore, it may be reliable but not valid. An instrument with a reliability coefficient of near 1.0 (a perfect score) has a high degree of reliability; the farther away the score is from 1.0, the less reliable is the instrument.

3. Objectivity. An objective instrument is one that achieves a quality of agreement among various users of the instrument; that is, when it is administered by two or more individuals independently, the results are similar. Objectivity is extremely important to "naturalistic" observation. When observing a participant, as with the RBI (Recreation Behavior Inventory), each independent observer must record the same results on each item. Naturalistic observation occurs as participants complete tasks in their natural surroundings, whether that be a recreation center or camp setting. It is especially useful with participants who are, for example, nonverbal and cannot accurately respond to verbal questions.

4. Usability. An instrument may possess the desired qualities of validity, reliability, and objectivity yet may not be appropriate or practical. A usable instrument is one that can be administered and scored within a relatively convenient time period, uses readily available materials, is not too costly, and does not place undue strain on staff.

Staff training. Training content should include: instrument criteria; assessment-evaluation instruments (availability and intended uses); data collection methods; statistical treatment of the data; use of collected data; and the evaluation report. Staff training commences with staff input into the development of the evaluation plan and continues as each phase is designed and implemented. One approach is to prepare with staff a listing of concerns appropriate to each phase of evaluation (see Exhibit 7-1). The identified concerns then guide the staff in their selection and/or preparation of instruments. After instruments are selected and/or prepared, staff must also be trained to administer the instruments and how to interpret and apply the results.

Evaluation Timetable. The timetable in which to complete the evaluation process should be determined based on the timetable for individual participant program plans. Yet, in reality, the agency calendar, fiscal year, due dates of the annual report, inspection dates, or the school calendar influence when evaluation data are collected. An evaluation worksheet (see Exhibit 7-2) is prepared which gives the timetable for administering the instruments and the specific staff duty assignments. The worksheet also lists the instruments which will be used to collect data during each program phase, the administrators, the respondents, and the data analysis procedures and persons assigned to interpret the data.

Program Revisions. Evaluation information is used to revise an activity or a process that occurs in any of the four programming phases. Evaluation may also reveal unanticipated but valuable information which is used to revise participant experiences, activities, leadership training, or resource management (see Exhibit 7-3). The staff must specify in the evaluation plan the procedures which will be used to make revisions in an ongoing program and at the conclusion of a program. Factors other than "statistics" may influence what and when program changes are made. Political climate, committee bias, priority given to evaluation by the manager, and the available budget to make unplanned adjustments may dictate what changes are actually made. Using well-documented information, staff are able to justify changes made during ongoing programs and as the program session or season changes. The timing of the fiscal year may actually determine when new programs are added or when major personnel changes affecting program offerings are made. The central factor influencing programming should be the functional level of each participant. Participants may periodically need to transition among existing programs to assure that their individual needs are met.

Exhibit 7-1
EVALUATION CONCERNS

Program Phase	Instrument(s)	Evaluation Concern
Assessment	Needs assessments Resource inventory Staff applications and interviews Leisure diagnostic tools	Have all data sources and information about the agency, community and participants been gathered?
Planning	Risk management checklists Individual participant and agency program plans Staff training program	Are goals, objectives, content, and leadership processes relevant and logically sequenced? Are staff and resources prepared and adequate?
Implementation	Participant logs and program progress sheets Activity/leadership evaluations and daily planning and evaluation forms	Is the program designed as intended? Is the population the same as the one for which program was designed? Are content, leadership, and management appropriate to participant and program objectives?
Evaluation and follow-up	Participant, program, volunteer, employee, parent, and administrator reports and transition plans	Were the participant and program objectives achieved? Were resources safe, adequate, and managed effectively? What were unanticipated outcomes? Which programs should be deleted, modified, and/or continued as implemented? Is participant behavior relevant to natural setting? Are transition plan objectives appropriate? Are support systems coordinated and communicating?

Exhibit 7-2

EVALUATION TIMETABLE

Program Phase	Instrument	Timetable	Administrators	Respondents	Data Analysis
Assessment	Participant needs assessments	Pre-registration 3 times/yr	Managerial staff	All new participants via interview	Managerial staff using ordinal statistics
Planning	Individual and agency program plans	Staff in-service week 3 times/yr	Leadership staff	All participants	Managerial staff using nominal statistics and narrative comments
Implementation	Activity evaluation	Bi-weekly during program session with each activity	Specialists and volunteers via observation	Leadership staff	All staff using ordinal statistics
Evaluation	Participation evaluation	Pre-transition or program termination	Specialists with leaders	Parents and participants	All staff using nominal and ordinal statistics with narration

Exhibit 7-3

FINAL PROGRAM EVALUATION FORM

Program Name: ______________________ No. ______ Date: __________
Leader: ____
Part-time Staff: _______________________________________
Volunteers: ____
Total Enrollment: ______________ Total Participant Service Units __________
Total Transportation Units: _____________________________

Directions: Enter rating on line before each statement using criteria:

1 - Inadequate, inappropriate, or NO
2 - Partially adequate, appropriate, or MAYBE
3 - Adequate, appropriate, or YES

SUMMARY

1. Program

Overall program operation: Inadequate _____ Somewhat Adequate _____ Adequate _____

__ Were program goals/objectives met?

__ Was program delivered as planned?

__ Were selected activities appropriate to goals and objectives?

__ Were activities presented in a progression recognizing participants' skills and experience levels?

__ Were activity planning and evaluation sheets used as intended?

__ Were adaptations/modifications appropriate?

Comments: (include unanticipated happenings) ______________________________
____
____

2. Resources

Overall resource quality: Inadequate _____ Somewhat Adequate _____ Adequate _____

__ Were resources appropriate for activities?

__ Were resources appropriate and accessible for participants?

__ Were safety rules and emergency procedures posted?

(Continued)

(Exhibit 7-3: Final Program Evaluation Form--Continued)

Comments: ____

____

____

3. Participants

	Inadequate	Somewhat Adequate	Adequate
Overall participant response:	_____	____	______

__ Were participants' skill levels appropriate to program goals and objectives?
  __ to activities?

__ Were participants' behaviors appropriate for activities?
  __ with other participants?
  __ toward staff?

__ Were participants' expectations compatible with activity objectives?

__ Did participants enjoy activity?

__ Will participants continue activity outside of Northern Suburban Special Recreation Association (NSSRA)?

Comments: ____

____

____

4. Leadership

	Inadequate	Somewhat Adequate	Adequate
Overall performance of leaders:	_____	_____	______
Specialist:	_____	_____	______
Part-time:	_____	_____	______
Volunteers:	_____	_____	______

__ Were activities selected and used to achieve program goals/objectives?

__ Were rules, regulations, and safety procedures followed?

__ Were participants' needs and behaviors managed appropriately?

__ Were leadership methods appropriate for activities?
  __ for participants?

__ Was supervision of staff adequate?

__ Were leaders knowledgeable of participants' abilities and implications of disability on participation?

(Continued)

(Exhibit 7-3: Final Program Evaluation--Continued)

___ Was leader-participant ratio adequate?

Comments: ______________________________

____

____

5. Issues or Concerns (encountered in program that have not already been addressed)

____

____

____

6. Program Recommendations

What suggestions would improve future program activities?

Activity: ______________________________

Leadership: ______________________________

Resources: ______________________________

Management and Policy Procedures: ______________________________

____

____

____

Staff Signature ______________________________ Date ______________

Formative Evaluation

The formative evaluation process is undertaken to identify strengths and weaknesses so that a program may be improved while it is being implemented. One concern is to determine if the program is being implemented as planned. Are the activities, staff interactions, scheduling, and resources appropriate? Is the program being managed so that participants achieve their individual objectives? The nature of unplanned and unanticipated events and outcomes is also recorded. Formative data are recorded using participant logs, attendance forms, and documentation on the Individual Recreation Plan (see Exhibits 7-4 and 7-5).

Exhibit 7-4

COMMUNITY LEISURE INTEGRATION PROGRAM

Contact Log

Purpose: Accompanies Individual Recreation Plan: Is completed by staff/volunteer to log progress in achieving integration goals.

This form is to be sent in (date) of each month.

Please follow these guidelines when using this form:

1. Only one participant per form.
2. Include weekly activity, location and time.
3. Any specific participant progress or concerns.
4. Any additional information which could be beneficial to future staff and volunteers.
5. Specify how the activity relates to the participant goals.
6. Highlight in red any information you want administrative staff to be aware of or attend to regarding participant progress.
7. Please PRINT neatly using BLACK ink.

Participant Name: ______________________________

Contact Person: ______________________________

Northern Suburban Special Recreation Association (NSSRA) Staff: ______________

Date & Time: ______________________ Entry ______________

____

____

____

____

____

____

____

Staff Signature: ______________________

Date: ______________

Exhibit 7-5

INDIVIDUAL RECREATION PLAN

PURPOSE: To ensure that appropriate objectives for each participant are stressed and that activities are conducted to reach the objectives.

DIRECTIONS: Please write the individual objective on each participant and at the end of each week, list the activities conducted to reach the objective. Also each week, add any additional information or any revisions of the goal. (Comments/Progress Notes recorded at end.)

PARTICIPANT: ______________________ DATE: ____________

PROGRAM: ________________ EVALUATOR: ______________

(I) OBJECTIVE:

ACTIVITIES:

CRITERIA	Week #2	Week #3	Week #4	Week #5	Week #6	Week #7	Week #8	Week #9
(1) Progress Noted, Continue Objective								
(2) No Progress Noted, Continue Objective								
(3) Objective Met as Stated								
(4) Objective Revised as Stated								

REVISION/NEW OBJECTIVE:

ACTIVITIES:

(II) OBJECTIVE:

ACTIVITIES:

CRITERIA	Week #2	Week #3	Week #4	Week #5	Week #6	Week #7	Week #8	Week #9
(1) Progress Noted, Continue Objective								
(2) No Progress Noted, Continue Objective								

(Continued)

(Exhibit 7-5: Individual Recreation Plan--Continued)
(3) Objective Met as Stated ______

(4) Objective Revised as Stated ______

REVISION/NEW OBJECTIVE:

ACTIVITIES:
______

COMMENTS: ______
______
______
______
______
______
______

PROGRESS NOTES: ______
______
______
______
______
______
______

The frequency of evaluation and the nature of its concern are dependent upon the program focus (therapeutic recreation, leisure education, or recreation participation). When the focus is on therapeutic recreation, there is likely to be more emphasis on collecting formative participant and program data. When the focus is on recreation participation, evaluation may be done less frequently and may focus more on program outcomes rather than individual participant's achievement of their objectives.

Formative evaluation enables instantaneous program revisions to be made while providing a data base for summative evaluation. Key questions to include in formative evaluation are:

1. Was the program implemented as planned? Were there modifications? If so, give the reasons for the modifications.
2. Were the activities and the leadership techniques appropriate to the participant's objectives?
3. Was the program organized and sequenced to enable achievement of participant and program objectives?
4. Were the available resources adequate to meet participant and program needs?
5. Were there unanticipated behaviors or achievements? If so, what might have caused them?
6. Was the staffing pattern suited to participant needs and available resources?

Periodic activity or program evaluation enables a manager to recommend staff changes or alternative activities and/or to redesign the program format to better meet participant needs or participant program choices (see Exhibit 7-6). The most expedient approach to data gathering must be utilized because staff time is most needed in direct services. Daily, or even weekly, formative evaluation of all participants or activities may not be feasible. A helpful management tool is to design a calendar which gives periodic due dates for participant assessments, logs, and interim evaluations.

Exhibit 7-6

ACTIVITY EVALUATION SHEET

Program Number/Site ______________________ Dates ______________
Goal Numbers ________ Enrollment __________ Attendance ____________
Participant Service Units ____________ Transportation Units ____________
Leader (name/number) ____

Part-time ____
Volunteer ____

Directions: Enter rating below session number for each of the listed criteria.

Rating Criteria:
1. Inadequate, inappropriate, or not observed.
2. Partially adequate, appropriate, or observed.
3. Adequate, appropriate, or achieved.

	Session Number							
1. PROGRAM	1	2	3	4	5	6	7	8
Activity skill requirements								
Activity sequence								

(Continued)

(Exhibit 7-6: Activity Evaluation Sheet--Continued)

Activity timing

Activity modifications

Activity carry-over value

	Session Number							
2. RESOURCES (facility, eq't)	1	2	3	4	5	6	7	8
Physical setting								
Quantity/Quality								
Availability								
Safe and maintained								
Accessible to participants								

	Session Number							
3. LEADERSHIP	1	2	3	4	5	6	7	8
Adequate number								
Properly trained								
Preparation								
Organization								
Directions								
Participant supervision								

(Continued)

(Exhibit 7-6: Activity Evaluation Sheet--Continued)

Participant behavior management ________________________________

Safety management ________________________________

Skills and competence ________________________________

Involvement ________________________________

Session Number

4. PARTICIPANTS 1 2 3 4 5 6 7 8

Skill level ________________________________

Social behavior ________________________________

Objectives/ outcomes ________________________________

Readiness/ response ________________________________

Enjoyment/ satisfaction ________________________________

Involvement ________________________________

Follow-up recommendations and comments:

Unanticipated events or outcomes not planned for in original plan:

Positive ________________________________
____

Negative ________________________________
____

Additional modifications needed ________________________________
____
____

Adjusting Services Following Formative Evaluation

When the program is not being implemented as planned or the individual and program objectives are either inappropriate or incompatible, adjustments or modifications are made in the delivered services. Major changes, such as the amount of time allotted to the activity or the addition of personnel, may not be feasible until the start of a new session or a new fiscal year.

Adjustments may need to be made to the assessment, planning, and/or implementation phase(s). Assessment information (see Part I of text) is reconsidered. The statement of participant needs and capabilities may not correspond to collected data. Likewise, resources believed available from the community may not materialize, or potential monies and staff might be inadequate or less skilled as once believed to be.

The tasks completed during the planning phase (discussed in Parts III and IV of the text) are also reconsidered. The existing program structure and the individual participant plans are studied to determine their compatibility with each other. The participants may be higher or lower functioning than was first believed; consequently, their objective criteria must be either increased or decreased in difficulty or the service areas must be restructured so programs reflect an appropriate focus. The content selected to enable achievement of participant and program objectives might require additional modification or substitution. Personnel might require additional training in certain leadership techniques or they may need to be reassigned to lead activities for which they are qualified or work with participants with whom they are comfortable. Staff and participant schedules may need to be altered to allow for transportation delays. Use of resources, such as room assignments or use of activity areas, may need to be reassigned to better match actual class size. Evaluation of the budget may indicate a need to reduce spending on program supplies.

The program schedule might need to be modified to allow staff more time to prepare lessons, to record participant data, or to discuss participant needs with caregivers. Operating policies are re-examined; to illustrate, it may be determined that fees for selected activities might be justified as a means of enrollment control. Emergency procedures are rewritten to take into consideration a new activity area or building design. Risk management procedures are redefined in view of, for instance, changes in staff-participant ratios or participant skill levels. A regenerated marketing effort might be undertaken to solicit more participants. A topic that may need to be discussed at staff in-services with therapeutic recreation and community recreation staff is their responsibility to integrate participants into community recreation center activities.

When changes are made in any phase of program development, consideration must be given to what else is affected. To illustrate, when objective criteria are rewritten during program implementation (discussed in Part V of the text), the summative or final evaluation must be redesigned to correspond to the new objectives. When staff require new or improved skills to complete job tasks, their personal-professional objectives are upgraded. When money is shifted within the budget, programs may have to be redesigned.

Summative Evaluation

The procedures employed to collect and analyze data at the conclusion of programs must be consistent with those used during formative evaluation. Thus, a staff member may again be assigned to lead an activity while another staff member collects data on the activity and/or the participants by observing them. The last few periods of a scheduled program or of a participant's known attendance may be set aside to gather summative data. Or, staff may again be assigned to maintain documentation on specific participants and programs, then collectively meet as a team to finalize the program adjustments and participants' transition plans.

If standardized evaluation instruments are used, data analysis may occur via computer and may require staff interpretation in the form of a narrative comment. To properly study and comment on summative data, staff must be allotted sufficient time to do the narrative reporting and to review the data collected during the assessment, planning, and implementation phases. The information gathered on the participants and the programs is the basis for writing the evaluation report and for recommending participant transitions to other programs or services.

Participants. The summative data on the participants includes a brief restatement of their initial assessments, including their needs, functional levels, participation history, and the objectives to be realized through program participation (see Exhibit 7-7). The central issue is whether or not the predetermined objectives were attained. Also, any unanticipated or unexpected results should be noted. Were the activities, resources, and leadership techniques appropriate to the participants' objectives? Were the objectives as written suited to the assessed needs and functional levels of the participants? Do the scores on standardized and staff-made instruments indicate improved functioning in behaviors essential to community living, such as communication, decision-making, and following directions? Do the changes warrant transitioning the participant?

The achievement of participant objectives is also influenced by factors unrelated to content, leadership techniques, activities, and management. Transportation, family support, funds available, positive or negative influences of other participants, staff leadership styles, and features over which limited control exists, such as the condition of the facility, traffic, or weather conditions, also influence participant behavior and achievement. In their narrative comments staff identify the effects of these influences on the individual participants. Unusual behaviors or unexpected consequences may or may not be able to be explained.

Staff are also responsible to keep track of and report various participant-related data, such as staff-participant cost ratios, participant- program cost factors, attendance demographics, the number of participants registered per program, supportive or volunteer staff used with various participants, indirect cost factors (such as postage, telephone, and utilities), or cost factors in comparison to the participant costs of other agencies (see Exhibit 7-8). These statistics become useful during preparation of the evaluation report and help to justify participant transitions.

Exhibit 7-7

PARTICIPANT EVALUATION

Participant Name: ______________________ Age: _______ Sex: M__ F __

1. PARTICIPANT ASSESSMENT

Functioning level(s) and need(s): ______________________

____

Objectives:

Primary: ______________________

____

Secondary: ______________________

____

2. PARTICIPATION HISTORY

Program participation (dates/activities): ______________________

____

Attendance: ______________________

Objectives Achieved: ______________________

Supportive Resources Required: ______________________

Staff Recommendations: ______________________

____

____

3. SUMMARY COMMENTS

1. Were the activities suited to participant achievement of the stated objectives? Explain by objective:

Yes _____ No _____ Comments: ______________________

____

____

(Continued)

(Exhibit 7-7: Participant Evaluation–Continued)

2. Was the participant in activities appropriate to the assessed functioning level/needs?

Yes _______ No ________ Comments: ____

3. Did the participant have the support resources to enable objective achievement?

Yes _______ No ________ Comments: ____

4. Were the leadership methods appropriate to the participant's functioning level/needs?

Yes _______ No ________ Comments: ____

5. Do the participant's attitude/skills/interests make the participant ready for transition?

Yes _______ No ________ Comments: ____

Assessed by: ______________________________ Date: ________________

Exhibit 7-8

PROGRAM EVALUATION

Name of Program ____________________

Location ____________________

Season ____________ Day ____________ Time ____________

Recreation Center Supervisor ____________________

Program Supervisor/Leader ____________________

Disability(s) of Participants in the Program ____________________

____

____

Age Range (indicate the number attending in each age category below):

___ 0 - 5 years

___ 6 - 12 years

___ 13 - 18 years

___ 19 - 24 years

___ 25 - 34 years

___ 35 - 44 years

___ 45 - 54 years

___ 55 years and older

Functioning Level(s): I II III (please indicate appropriate level below):

Cognitive . . . Level ________ Sensory-Motor . . . Level ________

Affective . . . Level ________ Social . . . . . . Level ________

1. Total number of times program was conducted ________
2. Total participant attendance (number of hours) ________
3. Total number of volunteers
   a. Senior Citizens ________
   b. Disabled ________
4. Total volunteer attendance (number of hours) ________
5. Total staff attendance (number of staff per program/class) ________
6. Total staff attendance (number of hours) ________

(Continued)

(Exhibit 7-8--Continued)

SUPERVISOR'S SUMMARY REPORT

Analysis of Evaluation Materials

1. Is the program enabling the achievement of participants' objectives?

2. Is the program suited to the population for which it was designed?

3. Is the program making the best use of the allotted resources?

4. Is the program properly staffed?

5. Is the program properly managed?

6. Are the activities properly selected, delivered, evaluated, and modified to meet the participants' objectives?

7. Summary of collected data and response to the above questions indicate the program should be: (check one)

_______ continued

_______ dropped

_______ modified as noted above/below:

Recommendations:

Signature

Date

Program. Evaluation of each program or content area is intended to ascertain whether or not, given the resources of the agency and the community, the programs achieved their objectives; that is, did "x" percent of the participants show documented behavior improvement? Did "x" number of agencies cooperate to provide services? Or did "x" percent of the community become aware of the leisure needs of all residents? Program evaluation is broader than participant evaluation. Included in program evaluation is consideration of all activities, participants, leadership, resources, and supportive networks. The decision to continue, modify, or drop a program is made after reviewing each major factor (activities, participants, leadership, resources, and supportive networks) as it relates to each of the other factors, with fiscal matters weighing heavily in the final outcome.

To determine whether the agency's program enabled achievement of participant objectives, each phase of program development is examined:

1. Did assessments accurately reflect the needs and functional levels of participants and the availability of resources, funds, and personnel?
2. Did the planned program structure, management, staffing, safety measures, media, and evaluative tools address the needs of the program users?
3. Was the program implemented and monitored as planned?
4. Were formative evaluation tools, such as risk management checklists, participant logs, and activity reports, used by the staff individually and collectively to justify their recommendations? Were data from these forms summarized and used to make appropriate service-adjustment recommendations (see Exhibit 7-9)?

Fiscal information is gathered by reviewing inventories, petty cash reports, monthly or seasonal allocation budget reports, and the statistics on program expenditures per participant. Whether a program is continued, dropped, or modified is influenced not only by cost but also by other quantitative factors, such as the actual number of participants serviced, the uniqueness of the services, and the multiple use of resources and program areas. Qualitative factors, such as participant well-being, integration, and comfort within the community, are becoming integral elements in summative evaluation.

Evaluation of therapeutic recreation programs covers both quantitative and qualitative factors, such as participant well-being.

Exhibit 7-9
EVALUATION SUMMARY

	Participants	Content	Leadership	Management
Assessment	60% are mentally or physically disabled	Request Social and sports events	Limited number of TR staff available	Prefer integrated and semi-integrated programs
Planning	Advisory committee formed to represent constituency	Focus on leisure education	Hire college TR, and spec. educ. majors	Use existing centers
Implementation	"x" number of participants involved	Activities listed with attendance noted	Staff per program recorded	Number of media contacts reported
Evaluation and follow-up	Total number of participants involved by functional and service levels available	Participant (no) enrolled in each area offered and in the community-at-large	Staff to participant ratios Number of agency's coordinating their services	Cost per program, with narrative summary of participant objectives achieved during and after program completion/ transition

Adjusting Services Following Summative Evaluation

The results of evaluation lead to discontinuation, modification, or continuation of an existing service or program. A program is discontinued when what it provides is not what is needed by the participants to achieve their objectives and/or when the required content and leadership make it not cost effective. Management of resources, staff, and content is modified so participant objectives are better met. A program may continue without major adjustments; subtle revisions, such as in the participant or program objective criteria levels, personnel changes, activity adaptations, or reassignment of program areas, may be all that is needed to better enable participant and program objectives to be realized.

Services are also adjusted to reflect the newly expressed interests of participants, the needs of new participants, budget adjustments, and alterations in supportive services, such as in transportation or in other programs being offered in the community. Sometimes, budget reductions and loss of support resources make it necessary to decrease the expected outcomes as listed in participant and program objectives. If this occurs, the narrative section of the evaluation report gives an explanation. These adjustments occur at the end of one session or season and before the next starts.

Transitioning

Although a program may continue to operate with only minor changes, the evaluation of an individual participant may indicate that the participant's needs cannot be met in the current program or that the participant has achieved all that is feasible in the particular program placement. Therefore, it would be beneficial for the participant to switch to a more suitable program and/or level within the agency or to attend suitable programs offered elsewhere in the community. Staff must be cautious when making transition recommendations to programs other than those within their agency. There are many uncontrollable events in the community environment which affect participant behaviors in settings other than the one in which they acquired and practiced community integration skills. Staff write a transition plan which contains their placement recommendations based on evaluation results. A transition plan provides continuity among existing programs and documents the staff's recommendations to the participant and significant others. Staff must be cautious to preserve the participant's right to confidentiality as the plan is being written and implemented.

A transition plan should include information on 1) the participant's objectives and activity history; 2) a description of the participant's leisure skills and the supportive resources used or required during participation; 3) recommended placements, goals, and activities; and 4) follow-up procedures (see Exhibit 7-10). This written plan is placed in the participant's file and complements the already existing participant plan. Staff meet with the participant and appropriate caregivers to share the transition plan. Arrangements are then made to contact appropriate resource personnel to implement the transition plan. Additional integration resources are found in Appendix C.

Evaluation Report

The concluding task is to record the results of the evaluation process in an evaluation report. This report can be a politically sensitive document; therefore, how the content is presented may be as significant as what is described. The knowledge and interest levels of the audience receiving the report influence the report format and content. Therapeutic recreation jargon and medical record-keeping terminology should be limited. The focus of the report should be on accountability. The numbers and figures should depict the costs per participant and per program. Staff productivity should be given in relationship to the programs offered and the participant outcomes. An evaluation report may be prepared yearly or following each program season. Segments of the report should be incorporated into the agency's annual report.

A suggested outline for the evaluation report is: 1) an executive summary or abstract; 2) content and design of the evaluation process; 3) results and conclusions; and 4) recommendations and costs. The introductory summary statement may be the most crucial portion of the report as it may be distributed to advisory committee members and significant others. Therefore, in a brief overview, the purpose, process, results, and recommendations are presented. This section may actually summarize the department's goals and objectives and may include data on the degree to which they were accomplished.

Exhibit 7-10

COMMUNITY INTEGRATION FORM

Purpose: Identify leisure options for individuals who come in or call in and request community recreation alternatives.

Date: ______________ Staff: ______________________________

Participant Name ______________________ Telephone ______________

Participant Address ______________________ Telephone ______________

Emergency Contacts ______________________ Telephone ______________

______________________ Telephone ______________

Primary Impairment ______________ Secondary ______________________

Precautions (seizures, medication, diet, exercise, special equipment, etc.) ______________

____

____

Leisure Interests(s): ______________________________________

____

____

Short-Term Goals (to 6 months or 1 year) ______________________

____

(Continued)

(Exhibit 7-10: Community Integration Form--Continued)

Long-Term Goals (after 1 year) ______________________________

____

Recommended Activities ______________________________

____

Supportive Resources (transportation, money, etc. available) ______________

____

Time Obligations (work, school, etc.) ______________________________

____

Referral:

Name of Agency Making Referral Referral to

Agency: ______________________________
Contact: ______________________________
Address: ______________________________
Telephone: ______________________________
Date: ______________________________

Additional Recommendations

Agency: ______________________________
Contact: ______________________________
Address: ______________________________
Telephone: ______________________________
Date: ______________________________

Follow Up:

Date: ____________________

Northern Suburban Special Recreation Association (NSSRA) Staff: ______________

Contact (name, agency): ______________ in person ____ by phone _____

Status of Participant Objectives: ______________________________

____

(Continued)

(Exhibit 7-10--Continued)

Participant Activities: (participant record) ______________________________

Staff/Participant Recommendations: ______________________________

INDIVIDUAL TRANSITION PLAN

Purpose: Identifies individuals who participate in agency sponsored or operated integration alternatives. Accompanied by the Placement and Referral Information form.

Participant ______________________________

Name: ______________________________ Telephone# ______________

Address: ______________________________

Emergency Contacts: ______________________________

Telephone# ______________

(Participant/Guardian): ______________________________ Telephone# ______________

Address: ______________________________

Participant Northern Special Recreation Association (NSSRA) History

NSSRA
Goals: ______________________________
Programs
Attended: ______________________________
Staff
Recommendations: ______________________________

Integration Levels: ______________________________

Recreation Plan
Goals/Objectives: ______________________________

(Continued)

(Exhibit 7-10--Continued)

Assessment
Information: ____________________

Program Title ____________________ # ____ Dates ____________
Location Address: ____________________ Phone# ____________
Supervisor/Instructor: ____________________ Phone# ____________
Accommodations
    Information/Referral ____________________
    Instructor Training/Notification ____________________
    Scholarship ____________________
    Transportation ____________________
    Equipment ____________________
    Facility ____________________
    Interpreter ____________________
    Volunteer ____________________
    Parent/Guardian Training/Contact ____________________
    Other ____________________

Program Title ____________________ # ____ Dates ____________
Location Address: ____________________ Phone# ____________
Supervisor/Instructor: ____________________ Phone# ____________
Accommodations ____________________
    Information/Referral ____________________
    Instructor Training/Notification ____________________
    Scholarship ____________________
    Transportation ____________________
    Equipment ____________________
    Facility ____________________
    Interpreter ____________________
    Volunteer ____________________
    Parent/Guardian Training/Contact ____________________
    Other ____________________

Follow-Up/Evaluation/Referral
    Date(s) ____________________
    Staff ____________________ Contact: In person ______ By phone ______

    Status of goals/objectives ____________________
    Appropriateness of accommodations ____________________
    Recommendations and referrals (activities & agencies) ____________________
    ____
    ____

(Exhibit 7-10--Continued)

PLACEMENT AND REFERRAL INFORMATION

Purpose: Accompanies Individual Transition Plan; is sent with participant to host agencies, parents, etc.

Date: ____________________

Participant's Name ______________________________ Phone# ________________

Address: ____

Emergency Contacts: Name ________________________ Phone# ________________
Address: ____

Program Class/Resource __________________________ Location ________________

NSSRA Supervisor/Contact: _______________________ Phone: ________________

Program/Class Instructor: ________________________ Phone: ________________

Dates: _______________________________________ Time: ________________

Orientation and Training
Date: ____
Time: ____
Place: ____
With Whom: ____
Accommodations Arranged: ____

Follow-up/Evaluation/Referral

Dates: ____________________________

NSSRA Staff: __________________ Contact __________ In person ____ By phone ____

Comments: ____

The second section of the evaluation report contains descriptions of the agency's services and of the evaluation process. Included are agency historical information, population information, financial data, program scope, staff, resources, rationale for evaluation, key evaluation concerns, measurement tools, and the data analysis process.

In the third section, the evaluation results are reported using charts, graphs, tables, and case studies to summarize collected information. Using these materials, staff share with appropriate audiences their conclusions about each area that was evaluated, such as participants, content, leadership techniques, and management. It is also effective to use audiovisual equipment to show programs as they naturally occur. Use of a photo album, videotape, slide tape, audio tape, newspaper clippings, and quotations also serves to inform lay audiences about the services which are offered.

The final section of the evaluation report presents a prioritized listing of recommendations, projected costs, and suggested time lines. From the written conclusions, staff make recommendations specific to the agency, the participants, and the resources. Proposed revisions in the assessment, planning, implementation, and evaluation phases are listed along with alternative suggestions and/or a "wish" list. Costs may be presented either as percentage increases or decreases in the budget or as specific dollar amounts. Time lines are suggested for carrying out the recommendations.

Summary

Evaluation determines if the offered programs are relevant to the needs of the participants. The quality of the evaluation phase is influenced by the degree of competency with which the previous three phases of program development were completed. Completion of the evaluation phase brings one cycle of the systematic planning process to an end while commencing the next.

Each step within the evaluation phase is dependent upon the preceding tasks and influences the ones that follow. Formative data are gathered during the assessment, planning, and implementation phases. These formative data are again reviewed as the summative data are collected. It is necessary to complete both participant and program evaluations to provide the material necessary to prepare the evaluation report. Programs are adjusted and participant transitions are recommended. Dissemination of the evaluation report to the proper audiences assures the accountability of therapeutic recreation programs to significant others which, in turn, supports the marketing efforts of the agency.

KEY TERMS

Concurrent validity. The degree to which two instruments obtain the same results when measuring the same concept.

Construct validity. The degree to which an instrument correctly defines the concepts being measured.

Content validity. The degree to which an instrument gives the proper weight to the concepts being measured.

Evaluation. The process of collecting data during (formative) and following (summative) program delivery to establish the effectiveness of the offered programs and services, the appropriateness of the leadership techniques, and the achievement of participant and program objectives.

Evaluation plan. The written document outlining the data-gathering instruments and techniques, the evaluation timetable, and the program revision process.

Evaluation report. A written document with supportive media, such as graphs, statistics, photos, and participant quotes, that documents the purpose, process, results, and recommendations of completed formative and summative evaluation.

Objectivity. The degree to which an instrument gives the same results regardless of who administers it.

Predictive validity. The degree to which an instrument can predict that a particular behavior will later occur.

Reliability. The degree to which an instrument gives the same results each time it is administered.

Usability. The convenience and ease with which an instrument can be used.

Validity. The degree to which an instrument measures what it purports to measure.

TRAINING EXPERIENCES AND STUDY QUESTIONS

1. Review the references to acquaint yourself with additional sources of evaluation tools and suggestions on proper evaluation techniques.

2. Complete participant and program evaluations using oral, written, and observational techniques. Which are more efficient in given situations?

3. Follow a participant through an agency's transition process. What agency adjustments are necessary to accommodate the participant's change from one program or service level to the next?

4. Conduct a naturalistic observation evaluation by making a photo album on a particular participant or program. Compare its effectiveness with a written evaluation, such as a paper/pencil instrument. What are the advantages and disadvantages of each?

5. Using a standardized instrument, such as the LDB (Leisure Diagnostic Battery), collect data on "normal" subjects. Then identify the factors which would affect the use of such an instrument with persons who are disabled.

6. Use a standardized instrument, such as the CERT Scale, with a sample number of participants. Under the same conditions, administer an agency-prepared tool intended to measure the same concepts. What are the pros and cons of each?

7. Which program factors influence the formative evaluation process? What can be done to better facilitate data collection during program operation?

8. Observe the process used by a specific agency to adjust its programs and services following summative evaluation. To whom and how is the evaluation report presented? What use is made of the evaluation report?

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Shafer, E.L., & Moeller, G. (1987). Know how to word your questionnaire. Parks and Recreation, 22(10), 48-52.

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Appendices

The material placed in the appendices, if used, will enhance the quality of community therapeutic recreation programs.

Appendix A lists assessment and evaluation resources and instruments. These references serve as guides to either develop or select instruments appropriate to the agency's needs. Also included is the assessment program of the Therapeutic Recreation Division, Cincinnati Recreation Commission.

Appendix B presents an Accessibility Survey List which staff may use as they survey the areas and facilities used by persons with disabilities in their agencies.

Appendix C contains sample integration planning and evaluation documents used by staff as individuals with disabilities transition to services in the community.

Appendix D contains potential contents of a volunteer manual. Staff might use these documents when they develop a volunteer manual appropriate for their agency.

Appendix A

ASSESSMENT AND EVALUATION INSTRUMENTS AND RESOURCES

ASSESSMENT AND EVALUATION INSTRUMENTS

Avocational Activities Inventory
Signpost Press, Inc.
P.O. Box 267
Sussex, WI 53089

CERT: Comprehensive Evaluation
in Recreation Therapy
Robert Parker, Chief of Recreation Therapy
Marshall I. Pickens Hospital
701 Grove Road
Greenville, SC 29605

LAB: Leisure Activities Blank
Consulting Psychologists Press
577 College Avenue
Palo Alto, CA 94306

LDB: Leisure Diagnostic Battery
Division of Recreation and Leisure Studies
P.O. Box 13857, NT Station
Denton, TX 76203

Leisure Activity Profile
Total Leisure Counseling Inc.
2730 Wilshire Boulevard, Suite 350
Santa Monica, CA 90403

Leisurescope
Leisure Dynamics
1425 Timber Valley Road
Colorado Springs, CO 80919

RBI: Recreation Behavior Inventory
Leisure Learning Systems, Inc.
2225 East McKinney
Denton, TX 76201

PUBLICATIONS ON AVAILABLE INSTRUMENTS

Buros, O.K. (Ed.). (1975). Personality, tests and reviews, Volumes 1 and 2. Highland Park, NJ: The Gryphan Press.

Johnson, O.G. (1976). Tests and measurements in child development, Handbooks 1 and 2. San Francisco: Jossey-Bass.

Mitchell, J.V., Jr. (Ed.). (1983). Tests in print III: An index to tests, test reviews and the literature on specific tests. Lincoln, NE: The University of Nebraska Press.

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Woody, R.N. (Ed.). (1981). Encyclopedia of clinical assessment, Volumes 1 and 2. San Francisco: Jossey-Bass.

COMPANIES FROM WHICH INSTRUMENTS ARE AVAILABLE

American Alliance for Health,
Physical Education,
Recreation and Dance
1900 Association Drive
Reston, VA 22091

American Guidance Service, Inc.
Publishers Building
Circle Pines, MN 55014

Consulting Psychologists Press
577 College Avenue
Palo Alto, CA 94306

Educational Guidance, Inc.
P.O. Box 511, Main Post Office
Dearborn, MI 48121

Educational Performance
Associates, Inc.
563 Westview Avenue
Ridgefield, NJ 07657

Psychological Services, Inc.
Suite 1200
3450 Wilshire Boulevard
Los Angeles, CA 90010

Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025

DIVISION OF THERAPEUTIC RECREATION
CINCINNATI RECREATION COMMISSION
THE ASSESSMENT PROCESS AND DEVELOPMENT OF THE INDIVIDUAL RECREATION PLAN

In simplest terms, Therapeutic Recreation is the use of recreation activities to achieve specific objectives. These objectives should be based on pre-determined participant needs.

The process of gathering information about a participant in order to identify needs relating to leisure skill development is known as assessment.

The assessment process is the single most important component of Therapeutic Recreation programming in that it provides the information necessary to individualize the program to the unique characteristics or needs of a single participant.

The assessment process generally takes place early in the program so that individual objectives may be identified and individualized activities designed.

The cornerstone of Therapeutic Recreation service is that individual objectives are based on assessment data and activities are designed to promote the individual objective:

Assessment
↓
Individual objective
↓
Activity that promotes objective

The Division of Therapeutic Recreation's assessment procedure is unique in that it is a continuous process and requires input from a number of individuals.

As a community based program, the initial screening and program placement is based on "self-assessment."

This "self-assessment" takes the form of a program brochure that describes the program services and skill level requirements. An annual information form is utilized to secure pertinent medical/behavior information. The participant and/or parent/guardian must attempt to select the program that is most appropriate for the participant's interests and needs.

The Division's Program Coordinators review the information provided by the participant/parent/guardian to ensure a correct program placement has been made.

Many times it is necessary to phone or to meet with the participant in order to supplement or confirm information on the annual information form.

Once a correct program placement has been made, the second level of the assessment process may take place. At this stage, the program staff attempt to identify specific areas in need of further development. The assessment instrument utilized by the Division includes 15 "performance areas" relating to leisure skill development.

The rating system for the Division's assessment instrument incorporates the skill level continuum (Levels I through IV). A participant is identified as functioning at level I, II, III, or IV for each performance area.

To assist the staff member in selecting the accurate skill level, a performance area resource book was developed. The resource book lists specific skills or behaviors that typify each skill level within the performance area.

Example: Social Interaction

Level I — nonperformance
— is indifferent to others
— etc.

Level II — occasionally initiates interaction with others
— etc.

By reviewing the specific skills identified in the resource book, the staff member will have an objective method of selecting the correct skill level for each performance area. **Please Note:** The assessment ratings are based on a standardized instrument (**Performance Area Resources Book**). Skill level ratings should be made based on the participant's performance relating to the book. Assessment ratings should not be based on comparisons to other participants in the program.

After a thorough assessment has been completed, the T.R. staff member will develop an Individual Recreation Plan (IRP) for each participant. The IRP is a written statement that clearly describes what the participant outcomes will be as a result of participating in the program. The IRP should be written in specific language with measurable terms. In other words, the IRP should be written in such a manner that it is very clear if the participant has or has not accomplished the objective. An effectively written IRP includes terms that are observable.

The IRP should not include vague terms such as "understands," or "enjoy." These terms are difficult to observe and open to many interpretations.

The staff member should use terms that describe a specific performance when writing the IRP. Performance words or "doing" words are much more measurable.

*Please Note: Be sure to remember to write the IRP in terms that describe what the participant will be doing, not what the staff member will be doing.

Example: The T.R. staff member will present participant with a variety of leisure activities to promote leisure choice making.

Who is this a goal for?

Who is "doing"something in this goal?

Better Example:

The participant will select one preferred activity when presented with a choice of three.

After a designated period of selecting and presenting the Therapeutic Recreation activities the staff member will evaluate the progress toward the individual recreation plan. The staff member will also review the assessment (skill level ratings for specific performance areas) to determine if any changes have occurred. It is very unlikely that changes will be apparent in the skill level ratings (assessment). Development in these areas will take place over a much greater period of time, if at all.

Progress should be noted, however, toward the individual recreation plan. If satisfactory progress is made toward the individual recreation plan, the activities being implemented are correct. If no progress or regression is noted, changes should be made in the type of activity, methods of presentation, or staff interventions. It may be necessary to review the individual recreation plan itself and to make revisions.

IMPORTANT INFORMATION
WHICH PROGRAM IS APPROPRIATE FOR YOU?

The Therapeutic Recreation programs have been developed with specific skill ranges in mind. Staff to participant ratios have been established based on the activities conducted and the skill levels of the participants. In order for the Division to provide the most appropriate program placement, it is necessary to identify each participant as being either at Skill Level I, II, or III. The program Skill Levels are explained below and are identified with the specific program information on the following pages. If you have questions concerning the correct program placement, please call the Division at 352-4014. If an inappropriate program placement is made, the Division will, based on the recommendations from program staff, seek to place the individual in a more appropriate program.

SKILL LEVEL CLASSIFICATIONS

SKILL LEVEL I Refers to participants who are in need of individual attention for the majority of their personal needs and program activities. Level I participants are in need of development of basic self-help skills, communication skills, socialization and motor coordination skills. Programs identified as being for Level I participants generally have a one to one or one to two staff to participant ratio.

SKILL LEVEL II Refers to participants who are able to function in group situations and, with minimal assistance, can communicate and manage personal needs. Level II participants have begun to refine basic motor and self-help skills. Programs identified as being for Skill Level II participants generally have a one to four staff to participant ratio.

SKILL LEVEL III Refers to participants who possess the skills necessary to learn high level recreation activities. Level III participants are able to communicate and manage personal needs with little or no assistance and have a high degree of development in socialization and motor skills. Programs identified as being for Skill Level III generally have a one to eight (or more) staff to participant ratio.

L.I.N.K. The Leisure Integration Network (L.I.N.K.) pertains to Skill Level III participants who are interested in a general (non T.R.) community recreation program. The T.R. staff will serve as an advocate for the participant and resource person to the general recreation staff member to facilitate a successful "mainstreaming" experience. To inquire about L.I.N.K. program opportunities, please call the Division at 352-4014.

THERAPEUTIC RECREATION STAFF

The Division of Therapeutic Recreation employs fulltime, professional staff with degrees in Therapeutic Recreation, Special Education, or related fields. The full time employees hold national certification in therapeutic recreation and specific speciality areas. The Division also employs approximately 50 part time employees who are trained to work with all ages and disabilities. Therapeutic Recreation staff hold certification in First-Aid, CPR, Adapted Aquatics, and other program areas. To inquire about employment opportunities, call the Division at 352-4014.

CINCINNATI RECREATION COMMISSION
DIVISION OF THERAPEUTIC RECREATION
SKILL LEVEL CONTINUUM

LEVEL I	LEVEL II	LEVEL III	L.I.N.K.	LEVEL IV
Participants in need of one to one or one to two staff to participant ratio for the majority of their personal needs and program activities. Level I participants are in need of developmen of basic socialization and communication skills, self-help and motor coordination skills. Activities for Level I individuals should stress development of basic socialization, sensory motor, self-help, and motor coordination skills.	Participants who are able to function in group situations and with minimal assistance can communicate and manage personal needs. Level II participants have begun to refine basic motor and self-help skills. Activities for Level II participants should stress group socialization and the refinement of fine and gross motor skills for higher level recreation activities.	Participants who possess the skills necessary to learn high level recreation activities. Level III participants can communicate or manage personal needs with little or no assistance and have a high degree of development in socialization and motor skills. Activities for Level III participants should stress refinement of skills for high level recreation activities and integrative programming.	Leisure Integration NetworK Participants who possess the skills necessary to participate in integrative recreation activities, with minimal specialized instruction or assistance.	Independent Leisure Functioning

INDIVIDUAL RECREATION PLAN

PURPOSE: To ensure that appropriate objectives for each participant are stressed and that activities are conducted to reach the objectives.

DIRECTIONS: Please write the individual objective on each participant and at the end of each week, list the activities conducted to reach the objective. Also each week, add any additional information or any revisions of the goal. (Comments/Progress Notes recorded on back.)

PARTICIPANT: ______________________________ DATE: __________

PROGRAM: ____________________ EVALUATOR: ____________________

(I) OBJECTIVE:

ACTIVITIES:

CRITERIA	Week #2	Week #3	Week #4	Week #5	Week #6	Week #7	Week #8	Week #9	Week #10
(1) Progress Noted, Continue Objective									
(2) No Progress Noted, Continue Objective									
(3) Objective Met as Stated									
(4) Objective Revised as Stated									

REVISION/NEW OBJECTIVE:

ACTIVITIES:

(II) OBJECTIVE:

ACTIVITIES:

CRITERIA	Week #2	Week #3	Week #4	Week #5	Week #6	Week #7	Week #8	Week #9	Week #10
(1) Progress Noted, Continue Objective									
(2) No Progress Noted, Continue Objective									
(3) Objective Met as Stated									
(4) Objective Revised as Stated									

REVISION/NEW OBJECTIVE:

ACTIVITIES:

COMMENTS:

PROGRESS NOTES:

CINCINNATI RECREATION COMMISSION
644 LINN STREET, SUITE 411
CINCINNATI, OHIO 45203

DIVISION OF THERAPEUTIC RECREATION

PERFORMANCE AREA RESOURCE PACKET FOR ASSESSMENT AND EVALUATION

DESCRIPTION

The following performance areas have been identified as competencies to be assessed and evaluated for participants involved in therapeutic recreation programs. This resource packet was developed to assist staff members in determining the skill level that most accurately describes the participants. These skill levels were not developed to label participants, but were designed to identify needs and to group participants with similar abilities.

MOBILITY (AMBULATORY)

This is the act or process of moving from one point to another. It is the ability to change or cause to change position or posture.

Mobility skills for ambulatory participants could include but would not be limited to:

1. Body awareness
2. Locomotion
3. Spatial awareness
4. Tempo/speed
5. Balance
6. Coordination

LEVEL 1

- Negative or nonperformance; no display of awareness
- Moves body parts while in supine position
- Moves body parts while in prone position
- Creeps
- Crawls
- Sits with maximum support
- Maintains kneeling position with maximum support
- Stands with maximum support
- Walks with total staff assistance
- Frequently falls or bumps into objects

LEVEL 2

- Aware of body parts
- Can move from one point to another awkwardly or with minimal assistance
- Controls body fairly well when moving; may have uneven gait
- Can walk up and down stairs holding rail for support
- Occasionally falls or bumps into objects
- Kicks an object from a stationary position

LEVEL 3

- Can move body from one point to another with no assistance
- Can adjust flow & speed of movement; suits locomotion to the situation
- Can balance on one leg
- Can kick an object at a target
- Can kick or hit a moving object with frequent success
- Shows sureness of movement; avoids obstacles
- Walks and runs skillfully
- Walks up and down stairs unaided

MOBILITY (NONAMBULATORY)

This is the act or process of moving from one point to another or changing position or posture as it relates to individuals in wheelchairs.

Mobility skills for individuals in wheelchairs could include, but would not be limited to:

1. Body awareness
2. Spatial awareness
3. Partial ambulatory skills
4. Wheelchair maneuverability

LEVEL 1

- Negative or nonperformance
- No display of awareness
- Lifts head while lying on stomach
- Reaches for, grasps, and releases objects
- Sits in wheelchair with maximum strap support
- Can hold head up when sitting with support

LEVEL 2

- Lifts upper body with hand support, while lying on stomach
- Moves trunk by walking on hands
- Sits, using no hands for support
- Maintains kneeling position when placed in that position
- Transfers from wheelchair to floor with assistance
- Can travel using a wheelchair in a barrier-free environment, moving forward and backward at will
- Can set and release brakes on wheelchair

LEVEL 3

- Independently travels using wheelchair in compact area moving forward and backward at will
- Travels up and down incline using wheelchair
- Transfers to and from wheelchair independently
- Assumes kneeling position independently

AFFECTIVE EXPRESSION

Outward display of feelings or emotions

LEVEL 1

- Nonperformance (displays no emotions)
- Displays emotions without apparent cause
- Seldom responds to situations (stimuli) with appropriate emotions
- Displays temper tantrums without obvious cause
- Displays temper tantrums whenever annoyed or frustrated
- Is physically aggressive toward self or others

LEVEL 2

- Frequently responds to situations with the appropriate emotions
- Occasionally displays temper outbursts
- Occasionally shouts or becomes upset
- Occasionally uses physical setting (i.e., time and place) to influence the appropriate expression of feelings

LEVEL 3

- Continually chooses to express appropriate emotions for the setting
- Uses acceptable ways of demonstrating feelings

EXAMPLES:

- Deals appropriately with anger
- Communicates feelings of anger
- Deals appropriately with success
- Deals appropriately with failure
- Deals appropriately with constructive criticism
- Reacts appropriately to praise
- Converses without shouting or becoming upset
- Controls self even when emotionally involved

SOCIAL INTERACTION

To actively participate in a positive manner with other individuals. Interactions can range from one to one contact to large group activities. They can be either verbal or nonverbal in nature. Social interaction can vary with duration and may range from a facial response or reaction to appropriate socialization in a variety of community settings.

LEVEL 1

- Nonperformance
- Is indifferent to others
- Becomes upset without apparent cause
- Occasionally demonstrates interest with the interaction of others
- Will give eye contact
- Will attend to a person in a one to one situation
- Can accept no change in routine without becoming upset
- Displays temper tantrum whenever annoyed or frustrated
- Runs from group or disrupts group
- Feels insecure or frightened, even in familiar situations

LEVEL 2

- Discriminates among familiar and unfamiliar people
- Generally exhibits self-control when faced with unfamiliar situations
- Occasionally initiates interaction with staff or peers
- Generally feels secure in new situations; may need some reassurance
- Occasionally accepts change

- Accepts changes when given an alternate plan
- Displays occasional poor sportsmanship
- Can accept winning, but not losing
- Enjoys himself/herself when persuaded to participate
- Can participate in simple team games with general supervision

LEVEL 3

- Feels secure in old and new situations
- Initiates interaction with staff and peers
- Rarely displays temper and maintains self control even when emotionally involved
- Shows interest in the conversation of others
- Conversations deal with reality
- Participates voluntarily in small and large group activities in an enthusiastic manner
- Will participate in a group without being the center of attention
- Takes turns
- Shares
- Offers suggestions for appropriate activities
- Respects rights of others
- Respects body space of others
- Behaves appropriately in public
- Behaves appropriately in a car
- Behaves appropriately while using public transportation
- Is a good winner and loser; displays good sportsmanship
- Contributes to the success of group social experience
- Can play simple team games

RECEPTIVE LANGUAGE

The way in which individuals receive and process messages including sounds, symbols, gestures, and signs. Receptive language includes auditory discrimination, memory, listening, comprehension (following directions), and the association of words with pictures, ideas, or basic concepts.

LEVEL 1

- Nonperformance
- Listens only with constant individual direction
- Shows interest in sounds of object
- Localizes sound with eyes
- Responds to facial expression and body language
- Responds appropriately to one word directions
- Expresses needs by taking listener by hand
- Expresses needs by pointing
- Reacts/responds to one or two word directions

LEVEL 2

- Recognizes familiar sounds
- Identifies familiar sounds
- Distinguishes intonation
- Looks at listener with appropriate eye contact
- Understands some sign language
- Occasionally remembers names of people and places
- Responds appropriately to a sequence of commands with individual direction

LEVEL 3

- Can recall information given earlier
- Consistently remembers names of people and places
- Can maintain eye contact with more than one person in group conversation
- Listens to others without interrupting
- Can attend a verbal presentation
- Can recall a sequence of directions

EXPRESSIVE LANGUAGE

The way in which individuals transmit messages by any means including sounds, symbols, gestures, and/or signs. Expressive language involves gesturing, verbal expressions, articulation, fluency, volume, phrasing, and quality of voice.

LEVEL 1

- Nonperformance
- Cries to make needs known
- Makes physically satisfying noises
- Imitates intonational patterns
- Imitates facial expressions and gestures
- Repetition of some words without appropriate stimulus (perseveration)
- Attempts to communicate, but communications have no apparent meaning
- Uses limited sign language
- Answers yes/no questions
- Uses appropriate volume rarely
- Is understood when listener knows what is being discussed
- Expresses needs by taking listener by the hand
- Expresses needs by pointing
- Expresses a message by a series of manual and expressive facial gestures

LEVEL 2

- Uses one word communication
- Can be understood by familiar persons only when combining gestures and/or words
- Engages in limited conversation only with a familiar person
- Engages in conversation, but is limited to direct responses
- Occasionally uses appropriate volume
- Communicates verbally, but is hard to understand
- Communicates in simple sentences
- Uses basic sign language

LEVEL 3

- Is easily understood by familiar and nonfamiliar people
- Communicates appropriate thoughts clearly (using either verbal or nonverbal means of communication)
- Communicates in sentences
- Engages in dialogue with peer
- Engages in casual conversations
- Sings songs with group

SAFETY

To determine the participant's awareness and behavior in a potentially dangerous situation. Freedom from danger or injury; security. The quality or condition of being safe.

LEVEL 1

- Negative or total unawareness of any dangerous or hazardous situation
- Unaware of danger in walking in front of a swing or slide, walking into the street, touching something hot, or handling sharp objects such as a knife or scissors
- Behaves safely only when taken by the hand and assisted through a potentially dangerous situation
- Will behave safely if: (1) taken by the hand and assisted across the street; (2) steered clear of the swing, slide, or pool edge; (3) watched constantly and given hand over hand assistance with cooking or cutting
- Behaves safely when verbally cautioned continuously through a potentially dangerous situation. They may not comprehend why, but will follow verbal instructions
- Will respond appropriately to constant verbal commands to: "stop," "go," "walk," "don't touch," . . . . May not be aware of actual danger, but will do as verbally directed most of the time

LEVEL 2

- Behaves safely in a group situation most of the time, by following examples of others
- Aware of dangerous situations, but needs constant verbal reminding or hand over hand assistance
- Aware of safety, but cannot personally physically remove self from a dangerous situation
- The individual will stay with the group when crossing the street, entering the pool area, and walking on the sidewalk; the individual will also do as others in the group do . . . stop, walk, sit, stand . . . .
- When asked, individual knows a situation is unsafe, but must be reminded often when the actual event is about to occur
- Definitely is aware of all unsafe situations, but is not physically able to remove self from it (some individuals with physical disabilities)

LEVEL 3

- Behaves independently in a safe manner and is aware of dangerous situations
- Has sound judgment when crossing the street, carrying something hot, or using a sharp instrument
- Is aware of and assists others who are potentially entering an unsafe situation

GROSS MOTOR

To use large muscle groups to perform physical activities such as crawling, walking, running, jumping, catching, throwing, etc. The ability for an individual to successfully perform gross motor skills is based on their degree of physical fitness, the amount of instructions provided, practice, and interest in the activities.

LEVEL 1

- Negative or nonperformance
- Requires direct physical assistance to perform basic gross motor skills
- Does not possess the physical ability to roll over, lift arms, or walk
- Can roll from their front to back . . . or back to front
- Can push ball with hand or foot
- Can independently get from point "A" to point "B"
- With physical and verbal assistance the individual will attempt to kick, catch, hit, or throw

LEVEL 2

- Can perform basic gross motor skill when given verbal and/or some physical assistance
- Performs basic gross motor skills independently, but in an awkward or poorly refined manner
- When verbally instructed and shown by exampl, "how to," the individual will run, jump, throw, catch
- Attempts most gross motor activities, but needs to refine skills to improve coordination, endurance, strength

LEVEL 3

- Performs basic gross motor skills independently
- Performs advanced gross motor skills when given verbal direction and role model
- Body balance, coordination, muscle tone, and endurance are average for a "normal" individual
- Uses refined gross motor skills to participate in high level games and activities
- Can run, jump, throw, catch, and kick independently
- Will successfully participate in more advanced activities (such as trimnastics, gymnastics, and team sports . . .) that require a high degree of gross motor coordination, endurance, and strength

FINE MOTOR

Fine motor assessment is made on a participant's manipulative skills, their ability to coordinate the use of their fingers and hands to accomplish basic self help skills, writing, and arts and crafts.

LEVEL 1

- Negative or nonperformance
- Is physically unable to use hands
- Requires hand over hand assistance and verbal prompts to accomplish basic fine motor skills
- Is unaware of ability to use hands and needs to be physically assisted with hand over hand motion to accomplish basic fine motor skills
- Will attempt and accomplish in an awkward manner some basic fine motor skills (can eat with fingers, turn a light switch on or off, push or touch a button, brush hair, etc.)

LEVEL 2

- Will attempt fine motor skills independently and will successfully accomplish them at least 50 % of the time
- Will accomplish fine motor skills, but needs to be verbally or physically prompted
- With hand over hand and/or constant verbal assistance, individual can accomplish most fine motor tasks successfully (such as holding a spoon, paint brush, etc.)
- Will attempt fine motor skills, but with poor eye/hand coordination; individual can only successfully accomplish skills on an occasional basis
- Individual is aware and attempts to zip coat, fasten buttons, grasp a cup, use a fork, use scissors/crayon/pencil, etc.

LEVEL 3

- Requires little to no assistance with fine motor skills
- Can independently handle most self help tasks (eating, drinking, dressing, brushing hair, brushing teeth)
- Will attempt and accomplish most fine motor skills independently
- Can handle small instruments easily (pencils, pens, scissors, brushes)
- Can grasp small objects easily such as marbles and beads; can also turn pages of a book or magazine

PARTICIPATION

The participant's willingness, to become engaged in the program activities. This may include individual, small group, and/or large group activities. Participation refers to cooperatively taking part in presented activities.

LEVEL 1

- Nonperformance; unaware that activities are taking place; indifferent to the actions of others
- Disrupts program activities (intentionally or unintentionally) by wandering through them, creating noises, disturbances, etc.
- Participates only when given direct physical assistance throughout activity
- Participates only when given continuous verbal direction throughout activity

LEVEL 2

- Requires some verbal encouragement to begin activity, but participates willingly after starting
- Engages in activities with one or two familiar participants, but not larger groups
- Joins group independently, but may not actively participate
- Participates for short periods of time, but quickly loses interest
- Will rejoin activity with verbal encouragement

LEVEL 3

- Participates independently in an enthusiastic manner
- Encourages others to participate in group activities
- Expresses pleasure with activities and wants to continue and/or repeat activity
- Initiates appropriate activities with others during unstructured program times

ENDURANCE

The ability for a participant to continue in a physical activity over a period of time. Duration of effort. Endurance may also include the participant's ability to maintain a degree of alertness and attentiveness over the specified activity period.

LEVEL 1

- Nonperformance; unable to maintain alertness/attentiveness for any period of time
- Unable to engage in physical activity for even five minutes
- Low level of attentiveness/alertness for majority of program period
- Requires assistance to maintain upright position for activities

LEVEL 2

- Maintains attentiveness/alertness through entire program period
- Can engage in physical activity for over five minutes
- Will re-engage in activity after a short rest period
- Participates in activities of a physical nature with verbal encouragement from staff

LEVEL 3

- Maintains attentiveness/alertness through entire program period
- Can engage in physical activity for over 15 minutes
- Requests activities of a physical nature; encourages others to continue in activity
- Shows no signs of tiring during activities; avoids rest periods
- Participates in self-initiated physical activities without need for staff encouragement

SWIMMING

To propel oneself in water by natural means.

LEVEL 1

- Nonperformance (won't get in water)
- Gets in, but is not comfortable
- Experiments with balance in the water

- Begins to overcome fear of water through movement exploration
- Becomes physically adjusted to the water, bobs, floats, and recovers

LEVEL 2

- Will propel self in the water for a distance of 10 feet (on their front and on their back)
- Can perform safety turns
- Will refine strokes and add rhythmic breathing
- Can jump in 10 feet of water, level off, and return to side of pool (Red Cross novice)

LEVEL 3

- Can do 30 deep water bobs and a three-minute survival float or inverted "C" for three minutes
- Can pass Red Cross beginner
- Can swim more than one stroke
- Understands the concepts of Archimedes' Principle and Newton's Law

COGNITIVE

Cognitive skills relate to the participant's general awareness, his/her ability to differentiate stimuli using the five senses and his/her ability to problem solve. Cognitive skills also relate to an individual's perceptual and intellectual development.

LEVEL 1

- Nonperformance; total lack of awareness
- Occasionally able to differentiate between several very different stimuli
- Occasionally able to differentiate between several very different objects
- Unable to recognize when problem exists
- Recognizes when problem exists and withdraws
- May display preference for certain food items
- Unable to identify personal items
- Responds to, but is unable to identify most environmental sounds
- Recognizes own name when called
- Able to use simple toys when shown
- Unable to respond appropriately to concepts involving direction

LEVEL 2

- Able to differentiate between a variety of similar stimuli
- Responds to and is able to identify most environmental sounds
- Carries out activities involving response to concepts of "up," "down,""in," and "out"
- Is able to identify objects not belonging to a category
- Recalls information given ten minutes prior
- Can reproduce demonstrated movements
- Recognizes when problem exists, and requests assistance
- Locates objects used frequently without direction
- Is able to identify staff members and several friends by name
- Understands concepts of time including "morning," "afternoon," "today," "tomorrow," "sooner," "later," "before," and "after"
- Identifies those personal belongings used frequently

LEVEL 3

- Is able to carry out activities involving concepts of left and right
- Is able to relate past experiences to current situations
- Identifies majority of program participants by name
- Recalls information given days prior
- Is able to think problems through to solutions
- Is able to identify coins and bills, and their values
- Is able to add numbers when only the number symbol is presented
- Is able to tell time using both digital and standard clocks/watches
- Is able to give complete directions to others
- Recognizes and responds appropriately to humor
- Identifies all personal belongings and numerous items belonging to other program members

SELF-HELP

Self-help skills involve the act of providing for or helping oneself without dependence of others; self-help skills could include, but would not be limited to:

1. Personal hygiene: toileting, bathing/washing, blowing nose
2. Eating: feeding, use of utensils, distinguishing edible/inedible objects, food preferences
3. Drinking: sucking, swallowing, use of cup/straw
4. Dressing: cooperates, buttons, zips, identifies own clothing

LEVEL 1

- Negative or nonperformance of self-help skills
- No display of awareness
- Awareness of need, but requires direction and assistance; a one-to-two staff to participant ratio
- Sucks, swallows, takes food from spoon
- Uses hand over cup method
- Can use a straw to drink
- Needs total assistance with toileting
- Needs total assistance with bathing/washing

LEVEL 2

- Limited acceptability
- Successfully performs skills with verbal assistance
- Performs skills independently with occasional success
- Spoon feeds self; drinks from a cup
- Needs occasional help with dressing and personal hygiene
- Uses utensils with some success
- Unwraps food, opens pop can
- Is able to use bathroom with minimal assistance

LEVEL 3

- Anticipates needs and acts accordingly
- Uses skills efficiently and independently
- Can prepare a sandwich; can set a table
- Locates food in grocery and pays for it
- Totally independent in toileting, personal cleanliness, and dressing

PUBLIC BEHAVIOR

Public behavior is the manner of conducting oneself while in the community . It is the response an individual shows to his or her environment.

Public behavior skills could include, but would not be limited to:

1. Showing consideration for others
2. Respecting property rights
3. Initiating necessary transaction with the public
4. Using public transportation in appropriate manners
5. Respecting body space of others
6. Behaving appropriately in a car

LEVEL 1

- Negative or nonperformance of skills
- No display of awareness
- Participates, but requires total or frequent individual supervision while in public; requires a one to one or one to two staff to participant ratio

LEVEL 2

- Participates, but requires occasional individual supervision while in public
- Responds most of the time to general group supervision
- Occasionally respects the rights of others

LEVEL 3

- Respects the rights of others most of the time
- Regularly responds to general group supervision
- Adjusts to flexible schedule
- Encourages others to behave in an appropriate manner
- Rides public transportation without assistance
- Makes necessary transaction while in public

PROGRAM SKILL SHEETS

Swimming Progression for Ambulatory Participants

Numbers (1-9) = Level 1 Numbers (10-16) = Level 2 Numbers (17-22) = Level 3

1. Is participant able to walk independently without the use of any assistive device?
2. Participant will enter pool on their own
3. Participant feels comfortable with balance in chest deep water, on their own
4. Participant will do basic walking movement exploration in pool
5. Physical adjustment: Participant will get hair, face, and eyes wet
6. Bobbing: Participant will do 15 rhythmic bobs
7. Eyes: Participant will have eyes open under water and can focus and recognize an object or person under water
8. Overcoming gravitational insecurity (G-I) or earthboundness: Participant will pick up stick in waist deep water
9. Participant will stand 2 feet or more away from edge of pool and fall to the wall
10. Participant will put belly on the bottom of the pool
11. Participant will do a tuck float for a count of 10 and recover
12. Participant can float on front with kick
13. Participant can float on back with kick
14. Participant can do basic front stroke with arms, legs, dog paddle crawl, or breast stroke and take a breath
15. Participant can propel on back with flutter kicks or finning
16. Participant can do all safety turns
17. Participant can jump in 10 feet of water and swim 10, 20, 30 feet—novice
18. Participant can do 30 deep water bobs
19. Participant can do a 3 minute survival float
20. Participant passed Red Cross Beginner
21. Participant passed YMCA Minnow
22. Participant passed Red Cross Advanced Beginner

Swimming Progression for Nonambulatory Participants

1. Is participant able to walk independently without use of any assistive device?
2. Participant is assisted into the water safely. (Please explain in comment section on emergency list).
3. Participant feels comfortable with balance in chest deep water assisted by staff
4. Participant will use bo-bath technique for walking, if possible, assisted by staff
5. Participant can stand in chest deep water on their own
6. Participant can walk in chest deep water on their own
7. Participant feels comfortable being pulled through the water on front, back, right, and left
8. Physical adjustment: Participant will get hair, face, and eyes wet
9. Bobbing: Participant can do 15 rhythmic bobs
10. Eyes: Participant can have eyes open under water and can focus and recognize an object or person under water
11. Participant will porpoise swim between two instructors with first instructor assisting hands on for support for 3 feet
12. Participant will porpoise swim between two instructors freely with no support for a distance of 3 feet
13. Participant feels comfortable on back with assistance
14. Participant can roll 180° from front to back to get a breath with assistance
15. Participant can roll 360° from back to back with assistance
16. Participant can get breath on front with assistance
17. Participant can front float and recover unassisted
18. Participant can back float and recover unassisted
19. Participant can get breath independently in some adapted manner. (Explain in comments section on emergency list)
20. Participant can swim independently 15 feet
21. Participant passed Novice
22. Participant passed Red Cross Beginner

Program

Director

Year

NAME	MOBILITY AMBULATORY	MOBILITY NON-AMBULATORY	AFFECTIVE	SOCIAL	RECEPTIVE LANGUAGE	EXPRESSIVE LANGUAGE	SAFETY	GROSS MOTOR	FINE MOTOR	PARTICIPATION	ENDURANCE	SWIMMING	COGNITIVE	SELF-HELP	PUBLIC BEHAVIOR				

Appendix B

ACCESSIBILITY SURVEY LIST

INDEX

1.00 PARKING
2.00 WALKS AND SIDEWALKS
3.00 CURB CUTS
4.00 CURBS AND CURB RAMPS
5.00 ENTRANCES AND EXITS
6.00 CORRIDORS AND FLOORS
7.00 WARNING SIGNALS AND HAZARDS
8.00 DOORS AND DOORWAYS
9.00 STAIRS AND HANDRAILS
10.00 PASSENGER ELEVATORS/ ESCALATORS
11.00 WATER FOUNTAINS
12.00 SANITARY FACILITIES
13.00 TOILET ROOM - WATER CLOSETS
14.00 TOILET ROOM - LAVATORIES
15.00 TOILET ROOM - FIXTURES
16.00 TOILET ROOM - BATHING
17.00 PUBLIC TELEPHONES
18.00 CONTROLS, LIGHT SWITCHES, AND CONVIENCE OUTLETS
19.00 POOL FACILITIES
20.00 SEATING SPECTATORS

CINCINNATI RECREATION COMMISSION

Division of Therapeutic Recreation

644 Linn Street
Cincinnati, Ohio 45203

Facility ____________________

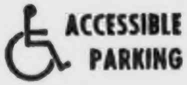
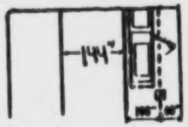
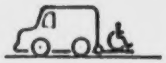
Address ____________________

____

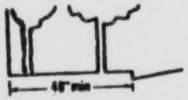
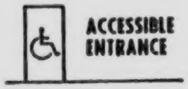
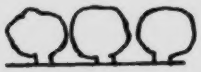
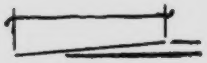
Telephone ____________________

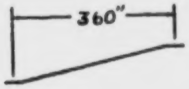
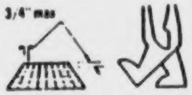
ACCESSIBILITY SURVEY LIST

1.00 PARKING

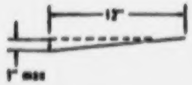
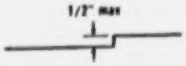
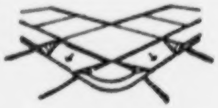
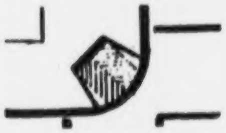
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS
1.01	ACCESSIBLE PARKING SPACES	Number of spaces: for every 25 spaces-1 accessible space up to 100 101-150, 5 301-400, 8 151-200, 6 401-500, 9 201-300, 7 501-1000, 2% of total over 1000, 20 plus for each 100 over 1000.				
1.02	IDENTIFICATION	Each accessible space shall be identified by the international symbol of accessibility.				
1.03	WIDTH OF STALL	Accessible spaces shall be 144" wide.				
1.04	SAFE ACCESSIBLE PATH	Are disabled compelled to utilize space behind parked cars to reach accessible pathways to the building?				
1.05	OBSTACLES	Are there any obstacles between the parking spaces and the accessible pathways to the building?				
1.06	CENTER POLICY	What is the center's policy on parking of abled bodied individuals in spots designated for disabled individuals?				

2.00 WALKS & SIDEWALKS

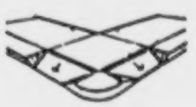
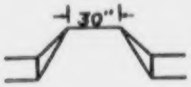
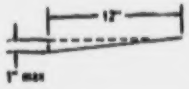
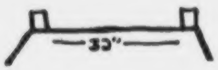
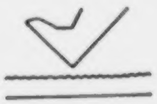
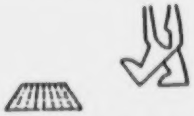
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS
2.01	WALK WIDTH	Minimum width shall be 48".				
2.02	SURFACE FINISH	Surface shall be a continuing, common, non-slip surface.				
2.03	ALTERNATE WALKWAY	Is there an accessible alternate walkway to enter?				
2.04	TREE PLANTINGS	Are tree limbs at least 90" high above walk?				
2.05	SHRUB PLANTINGS	Are shrubs trimmed completely out of the way of the path?				
2.06	GRADIENT WITH HANDRAIL	The maximum gradient of any sidewalk where a handrail is provided shall not exceed 8:33%.				
2.07	GRADIENT	The maximum gradient of any sidewalk shall not exceed 5%.				

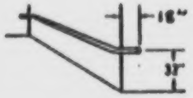
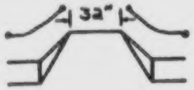
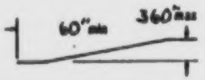
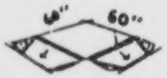
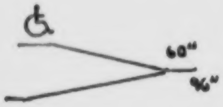
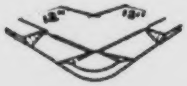
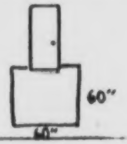
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
2.08	LANDINGS	Minimum length of landings shall be 36" at intervals of 360" maximum.				
2.09	DANGER AREAS	Are there grates, sudden drop-offs, open or raked joints, etc., in the path? If yes, please list.				

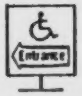
300 CURB CUTS

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
3.01	CURB SURFACE	Curb surface shall be nonslip.				
3.02	LONGITUDINAL SLOPE	Curb ramps shall be 1" in 12" (maximum). Sloped sides shall be 1" in 8" (maximum).				
3.03	CURB LIP	Curb lip at bottom shall be ½" (maximum).				
3.04	PARKING PREVENTIONS	Are there provisions made to prevent parking in front of ramps?				
3.05	INTERSECTIONS	At intersections, does position of ramp allow safe access to crosswalk?				

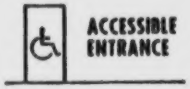
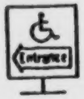
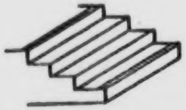
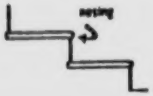
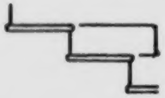
4.00 CURBS & CURB RAMPS

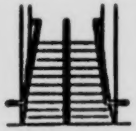
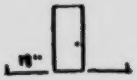
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
4.01	EXTERIOR RAMPS	Are there accessible exterior ramps available?				
4.02	RAMP WIDTH	Minimum ramp width shall be 30".				
4.03	LONGITUDINAL SLOPE	Maximum slope shall be as follows: 2ft. ramp-12.5% 3ft. ramp-8.33% 8ft. ramp-10.0% 60ft. ramp-8.3% 160ft. ramp-6.25%				
4.04	CURB RAMPS	Curbs shall be present at open sides. Minimum distance between curbs shall be 32".				
4.05	RAMP EXTENSION	Minimum level distance at bottom of a ramp shall extend 6".				
4.06	SURFACE TEXTURE	Shall be a nonslip surface.				
4.07	RAMP OBSTRUCTION	There shall not be any obstructions on the surface of the ramp.				

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
4.08	HANDRAIL DIMENSIONS	Handrails on each side of ramp shall be between 30" and 34" above ramp surface and shall extend 18" beyond top and bottom of ramp.				
4.09	HANDRAIL CLEARANCE	Minimum clearance between handrails shall be 32".				
4.10	LANDINGS	Shall be present if ramp extends beyond 360". 360" shall be the maximum distance between the landings. 60" shall be the minimum distance.				
4.11	LANDING TURNS	The minimum length at each landing with a turn shall be 60".				
4.12	SWITCHBACKS	Landings at switchbacks shall have a minimum length of 60" x 96".				
4.13	LANDING EXTENSIONS	Landings shall extend beyond edges on both sides 12".				
4.14	LANDINGS AT ENTRANCES	Landings at entrances shall be 60" x 60" with an outswing door and 36" x 60" with an inswing door.				

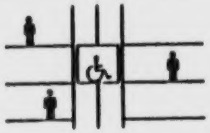
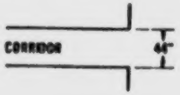
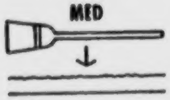
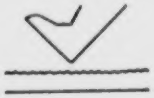
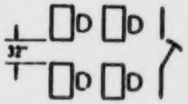
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
4.15	ALTERNATE ACCESSIBLE PATH	Is there an alternate accessible path?				
4.16	RAMP LIGHTING	Is lighting provided and utilized on ramps?				

5.00 ENTRANCE & EXITS

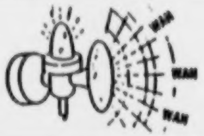
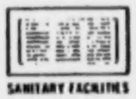
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
5.01	ENTRANCE	Record the most accessible public entrance.				
5.02	ALTERNATE ENTRANCE	Is there an alternate accessible entrance within 240"?				
5.03	ENTRANCE RAMP	Is there an accessible public ramp at this entrance?				
5.04	EXTERIOR FLOOR ACCESSIBILITY	Are all floors accessible from exterior entrances?				
5.05	ENTRANCE STEPS	Are there steps at the entrance listed in 5.01? If yes, how many? If no, go to 5.09.				
5.06	STEP NOSING	Do the steps have a sloped nosing?				
5.07	STEP DIMENSIONS	Record the height and depth of the largest step.				

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
5.08	ENTRANCE HANDRAILS	Are there 2 handrails accompanying the exterior steps?				
5.09	LANDING EXTENSION	Landing shall extend 18" beyond door.				

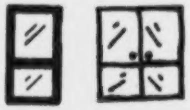
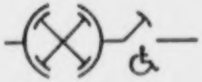
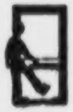
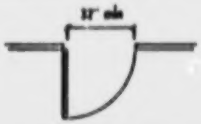
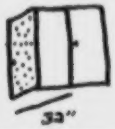
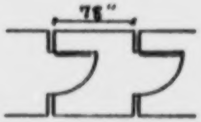
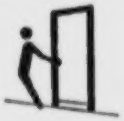
6.00 CORRIDORS & FLOORS

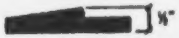
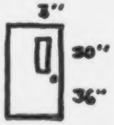
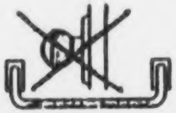
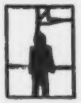
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	COMPLIANCE NO	COMMENTS
6.01	INTERIOR FLOOR ACCESSIBILITY	Are all floors accessible from the inside of the building?				
6.02	WIDTH	Minimum corridor width shall be 44".				
6.03	FLOOR SURFACE	Floors shall be nonslip or low pile carpet.				
6.04	CARPET FLOOR	Carpeted surface shall be flushed with adjacent surfaces.				
6.05	PROTRUDING OBJECTS	Record all ashtrays or other objects protruding into corridors.				
6.06	INTERIOR RAMPS	Are there accessible interior ramps?				

7.00 WARNING SIGNALS & HAZARDS

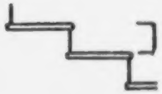
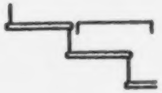
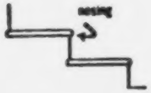
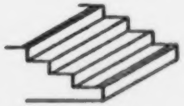
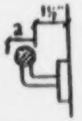
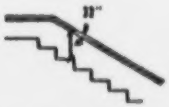
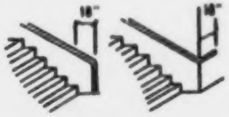
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
7.01	EMERGENCY TELEPHONE NUMBERS	Are emergency phone numbers posted so that persons who are disabled can utilize them? Attentio visual & hearing impaired.				
7.02	EXIT SIGNS	Are exit signs and directions easily identifiable to persons who are disabled? Attentio visual & hearing impaired.	EXIT			
7.03	FIRE EXIT SIGNS	Are fire exit signs and directions easily identifiable to persons who are disabled? Attentio visual & hearing impaired.	FIRE EXIT			
7.04	SIGNALS	Are visual signals and audible signals accompanied by each other?				
7.05	SIGNS	There shall be no low hanging signs.				

8.00 DOORS & DOORWAYS

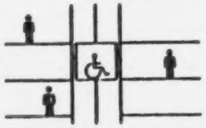
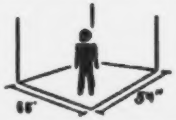
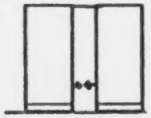
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
8.01	DOORS	Are the majority of the doors single-leaf or double-leaf?				
8.02	REVOLVING DOORS	Are there revolving doors?				
8.03	AUTOMATIC DOORS	Minimum distance between door and activation device shall be 42".				
8.04	SINGLE WIDTH	Doorway shall have a clear unobstructed width of 32" at narrowest point with the door open.	 32" min			
8.05	DOUBLE WIDTH	Minimum clear opening at narrowest point between back of open door and front of closed door shall be 32".	 32"			
8.06	CONSECUTIVE DOORS	Space between two consecutive doors shall be a minimum of 78".	 78"			
8.07	DOOR PRESSURE	Maximum effort to operate doors shall not exceed 8 lbs interior and 15 lbs exterior.				

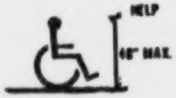
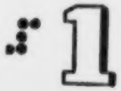
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
8.08	THRESHOLDS	Maximum edge height for interior and exterior thresholds shall be ½".				
8.09	DOOR SWING	Do the majority of the doors swing in or out?				
8.10	VISION PANELS	All corridor doors shall have functional vision panels which are vertically mounted at least 36" from the floor,				
		not less than 3" wide and not less than 30" long.				
8.11	DOOR HANDLES	Are the majority of the door handles of a lever type?				
8.12	KNURLED DOOR HANDLES	Shall be required on all non-public doors which may prove dangerous to persons who are disabled.				
8.13	DOOR CLOSERS	Are there low-hanging door closers protruding dangerously into the paths of the facilities users?				

9.00 STAIRS & HANDRAILS

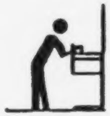
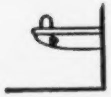
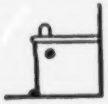
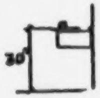
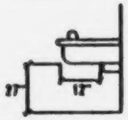
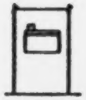
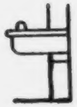
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
9.01	STAIR RISERS	Maximum riser height shall not exceed 6" exterior and 7" interior.				
9.02	TREAD DEPTH	Minimum tread depth shall be 14" exterior and 10" interior.				
9.03	TREAD NOSING	Maximum nosing projection shall be 1" sloped.				
9.04	TREAD SURFACE	Shall be made of nonslip or low pile carpet.				
9.05	HANDRAIL DIAMETER AND CLEARANCE	Shall be 1½" - 2" in diameter and 1½" or more from wall.				
9.06	HANDRAIL HEIGHT AND LOCATION	Handrails shall be installed on both sides 32" above nosing.				
9.07	HANDRAIL EXTENSION	Handrails shall extend 18" beyond top and bottom step.				

10.00 PASSENGER ELEVATORS/ESCALATORS

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	COMPLIANCE NO	COMMENTS
10.01	ESCALATORS	Are there public escalators available?				
10.02	ELEVATORS	Are there public elevators available? If yes, go to 10.03. If no, go to 11.00.				
10.03	FLOOR ACCESSIBILITY	Elevator shall allow access to all floors used by general public.				
10.04	EXTERIOR CALL BUTTONS	Shall not exceed 54".				
10.05	DOOR DIMENSIONS	Shall have a minimum clear opening of 32".	ELEVATOR 32"			
10.06	CAB DIMENSIONS	Shall have a minimum floor space of 60" x 60" or 54" x 68".				
10.07	SENSING DEVICE	Is the elevator equipt with a safety-edge door with a sensing device?				

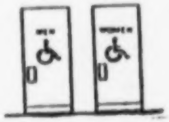
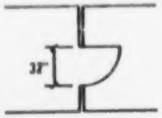
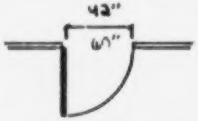
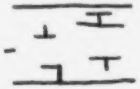
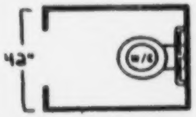
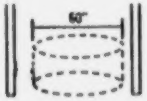
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
10.08	INTERIOR CONTROLS AND EMERGENCY CALLS	Shall not exceed 54".				
10.09	CONTROL IDENTIFICATION	Are there braille symbols or raised or recessed numbers and letters near control buttons?				
10.10	FLOOR INDICATING SIGNS	Each elevator at each floor shall have raised numbers/letters 42" above floor door jam.				

11.00 WATER FOUNTAINS

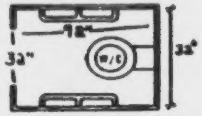
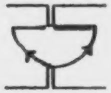
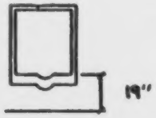
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS
11.01	ACCESSIBLE FOUNTAINS	There shall be at least one accessible fountain per floor.				
11.02	SPOUTS AND CONTROLS	There shall be up-front spouts and controls.				
11.03	WATER CONTROL	There shall be hand operated or hand-foot operated controls.				
11.04	CONTROL HEIGHT	Shall not exceed 30"				
11.05	KNEE CLEARANCE	There shall be a clear unobstructed knee space 27" high and 12" deep.				
11.06	CIRCULATION SPACE	Area around the water fountain shall be devoid of stairs and other obstructions.				
11.07	RECESS	Is the water fountain recessed? If no, go to 11.08. If yes, how deep is the water fountain recessed?				

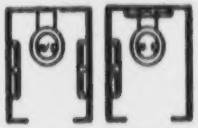
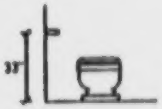
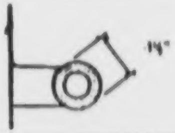
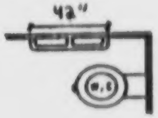
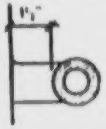
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
11.08	ALCOVE CLEARANCE	Is the water fountain placed in an alcove? If no go to 12.00. If yes, the alcove shall have a minimum width of 45".				

1200 SANITARY FACILITIES

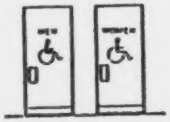
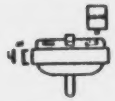
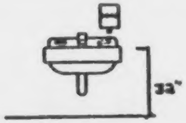
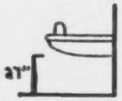
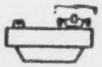
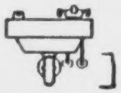
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS	
				YES	NO		
12.01	GENERAL	Is there an accessible toilet room available marked with accessibility symbol?					
12.02	DOORWAYS	Doorways leading to toilet rooms shall have a minimum width of 32".					
12.03	DOOR WIDTH	60" minimum if door swings out, 42" minimum if door swings in.					
12.04	SCREEN WALL	If there is a screen wall, record the distance between the door and screen.					
12.05	PATH OBSTRUCTIONS	List any obstructions, (trash receptacles,etc.) blocking path.					
12.06	PATH CLEARANCE	Path to accessible stall shall have a minimum width of 42".					
12.07	FLOOR SPACE	Area in front of stall shall have a minimum clear floor space of 60" x 60".					

13.00 TOILET ROOMS – WATER CLOSET

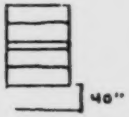
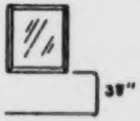
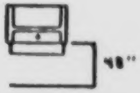
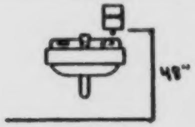
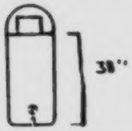
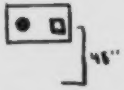
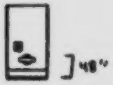
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS	
13.01	NUMBER OF ACCESSIBLE STALLS	There shall be 1 toilet stall for the disabled per restroom.					
13.02	STALL DIMENSION	When stall door is open the clear entrance shall be 32" width shall be 42", depth shall be 72".					
13.03	DOOR SWING	Does the stall door swing in or out?					
13.04	WALL MOUNTED	Minimum length with wall-hung water closet shall be 60".					
13.05	FLOOR MOUNTED	Floor-mounted water closet shall be 72".					
13.06	WALL MOUNTED URINAL	Lip height shall be 19" from the floor.					
13.07	FLOOR MOUNTED URINAL	Are the floor-mounted urinals level with the main floor?					

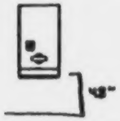
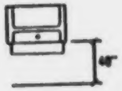
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS	
				YES	NO		
13.08	CONTROLS	Are the flush controls hand operated?					
13.09	GRAB-BARS	Two grab-bars shall be present in each accessible stall.					
13.10	GRAB-BAR HEIGHT	Shall be installed 33" from the floor.					
13.11	GRAB-BAR DIAMETER	Shall have a diameter of 1½".					
13.12	GRAB-BAR LENGTH	Shall have a minimum length of 42".					
13.13	GRAB-BAR WALL CLEARANCE	Shall be 1½" from the wall.					
13.14	GRAB-BAR SUPPORT CAPACITY	Shall have a minimum support capacity of 250 lbs.					

14.00 TOILET ROOMS - LAVATORIES

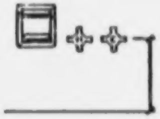
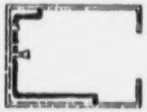
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS	
14.01	GENERAL	Each sanitary facility shall have one accessible lavatory per restroom.					
14.02	LAVATORY APRON LENGTH	Maximum apron length shall be 4".	 				
14.03	LAVATORY FLOOR TO APRON LENGTH	Minimum distance between floor and apron top shall be 32".	 				
14.04	UNOBSTRUCTED KNEE CLEARANCE	Shall be 27" from bottom of apron to floor.	 				
14.05	WATER SUPPLY CONTROLS	Record the type of lavatory controls used; single-lever, wrist-blade, etc.					
14.06	INSULATION	Are the lavatory water lines and drains insulated?					

15.00 TOILET ROOMS - FIXTURES

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS	
				YES	NO		
15.01	SHELVES	The height to one shelf top shall not exceed 40".					
15.02	MIRRORS	The height from the mirror bottom to floor shall not exceed 38".					
15.03	TOWELS	Maximum height for towels shall be 48".					
15.04	SOAP DISPENSER	Maximum height shall be 48".					
15.05	DISPOSAL UNITS	Maximum height shall be 38".					
15.06	CONTROL KNOBS	Maximum height to hand dryer control knob shall be 48".					
15.07	SANITARY NAPKIN DISPENSER	Maximum height to sanitary napkin dispenser coin slot and handle shall be 48".					

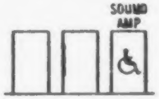
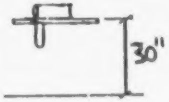
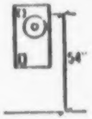
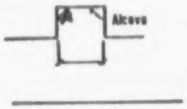
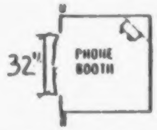
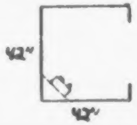
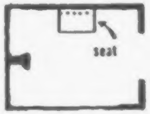
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS	
				YES	NO		
15.08	VENDING MACHINE	Maximum height to vending machine mechanism shall be 48".					
15.09	OTHER	Items not mentioned shall not exceed 40".					

16.00 TOILET ROOMS – BATHING

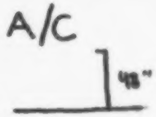
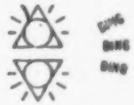
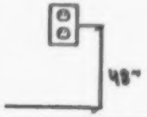
CHARACTERISTICS		REQUIREMENTS		COMPLIANCE YES	NO	COMMENTS	
16.01	SHOWER ACCESSIBILITY	Can a person in a wheelchair wheel into the showers?					
16.02	TURNING SPACE	Is there room to turn a wheelchair around in the shower?					
16.03	SHOWER KNOBS	Are the shower knobs usable by all disabled persons?					
16.04	SHOWER RAILINGS	Are there accessible hand railings on all sides in the shower?					
16.05	SHOWER BENCH	Is there a bench in the shower to sit on? If so, record the floor to seat dimensions.					
16.06	SHOWER HEAD	Is there a detachable shower head?					
16.07	CHANGING AREA TURNING SPACE	Is there room to turn a wheelchair around?					

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS	
				YES	NO		
16.08	CHANGING AREA PASSING SPACE	Is there room to allow one wheelchair to pass another wheelchair?					
16.09	CHANGING AREA BENCHES	Are there level benches? Record their dimensions.					
16.10	CHANGING AREA BENCH BACK SUPPORT	Do the benches have back support?					

17.00 PUBLIC TELEPHONES

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
17.01	ACCESSIBLE TELEPHONE	Where public telephones are provided, one must be accessible.				
17.02	DIRECTORY	Permanently attached phone directory where provided, shall be available at a level of 30" from the floor.				
17.03	HEIGHT TO COIN SLOT, DIAL AND HANDSET	The coin slot, dial and handset shall be within 54" of the floor.				
17.04	ALCOVE	Is the telephone located in an alcove?				
17.05	TELEPHONE BOOTH DOORS	Telephone booth doors shall have a minimum clear width of 32".				
17.06	TELEPHONE BOOTH FLOOR SPACE	All telephone booths shall have a minimum clear floor space between walls of booth of 42".				
17.07	TELEPHONE SEAT	Does the telephone seat fold out of the way?				

18.00 CONTROLS, LIGHT SWITCHES, & CONVIENCE OUTLETS

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
18.01	AIR CONTROLS	Controls for heating, cooling, and ventilation should not be more than 48" above the floor.				
18.02	ALARM CONTROLS	Controls for fire alarms and other warning devices should not be more than 48" above the floor.				
18.03	LIGHT SWITCHES	Light switches should not be more than 48" above the floor.				
18.04	OTHER CONTROLS	Frequently used controls such as drapery pulls, etc. should not be more than 48" above the floor.				

19.00 POOL FACILITIES

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
19.01	LIFTS AND RAMPS	Is there a lift or ramp available to allow persons who are disabled access to the pool?	♿			
19.02	LIFESAVING/ FIRST AID	Is lifesaving/ first aid equipment accessible to participants who are disabled?	✚			

20.00 SEATING & SPECTATORS

CHARACTERISTICS		REQUIREMENTS		COMPLIANCE		COMMENTS
				YES	NO	
20.01	CLEAR PATHWAYS	Are pathways clear and accessible to all spectator areas? If no, record barriers.				
20.02	WHEELCHAIR SEATING SPACES	Are spaces available for persons utilizing wheelchairs to observe the action without being endangered by the action?				
20.03	OTHER SEATING SPACES	Are seats available to persons using adaptive devices to observe the action without being endangered by the action?				
20.04	SEATING CAPACITY	Do spectator spaces on the floor make up 2% of the seating capacity?	2%			

Appendix C

INTEGRATION PLANNING AND EVALUATION DOCUMENTS

INTEGRATION INITIATIVE

Northern Suburban Special Recreation Association
Revised July, 1990

Mission Statement

The Northern Suburban Special Recreation Association (NSSRA) believes that recreation and leisure are important aspects of every individual's lifestyle.

By providing a range of services, NSSRA strives to meet each individual's recreation needs. NSSRA defines integration as those services enabling participants to reach an optimal level of independent leisure functioning within the community.

Through the combined efforts of NSSRA, the participant, parent/guardian, park districts, and other related service providers, individualized recreation plans are designed to facilitate the participant's involvement in programs and services compatible with their functioning ability. Simultaneously, programs and services are provided by NSSRA to enhance the awareness, knowledge, and accessibility of the residents and resources within the environment to the integration of individuals with disabilities into the community. More specifically, the intent of this NSSRA endeavor is to accomplish the following goals:

GOALS: Participant

Experience recreation participation opportunities in the community with individuals with and without disabilities.

Experience recreation that is enjoyable and self-satisfying.

Gain and maintain recreation skills used in community recreation alternatives.

Acquire social-emotional, educational, and support skills that enhance recreation participation in the community.

GOALS: Agency

Create awareness among parents/guardians that facilitates the integration/transition of the participant through appropriate NSSRA programs and services, and community integration experiences.

Provide education and information to NSSRA staff and volunteers, member district personnel, and other related service providers that promotes the participants' integration/transition through NSSRA, member districts, and other community recreation experiences.

Encourage programmatic and physical accessibility to enhance the optimal participation level of individual participants.

Network with those persons and resources to assure each individual the most reasonable, available recreation alternative within the community.

PROGRAM PROCESS

Step 1 CONTACT/REFERRAL

Contact to NSSRA for integration possibilities would be achieved through:

- Parent/Guardian making contact to NSSRA through integration marketing materials.
- Special Education or other related service personnel make contact on behalf of participant through integration marketing materials.
- NSSRA outreach staff make recommendation on behalf of participant for integration.
- NSSRA programming staff/volunteer make recommendation on behalf of participant for integration.
- Park District staff contact NSSRA regarding the special needs of a participant in their programs.
- Other specialists (OT, PT, clinical therapists) contact NSSRA requesting community placements.

Step 2 INTAKE

Once contact has been made, the NSSRA Integration Specialist would meet with participant and/or guardian to assess programming/integration possibilities.

- Leisure interests, preferences, assessment.
- Background on home and family life, social, medical histories.
- Consent forms signed to allow NSSRA to request Individualized Education Plan (IEP) and/or recommendations on integration from other service providers (e.g., special workers, vocational rehab, OT, PT, therapeutic recreation specialists).
- Participation criteria assessment.

Step 3 DEVELOPMENT OF INDIVIDUALIZED RECREATION PLAN (IRP)

Through assessments, program/integration recommendations are made by the Integration Specialist. The plan (IRP) will present goals, objectives, program/service options/integration levels, evaluation criteria and service delivery time frame.

Step 4 PARTICIPATION/MONITORING

Ongoing observation and evaluation by staff to recommend adjustments in the implementation of the individual recreation plan, and to gather information for the planning meetings and participant transition plans.

Step 5 EVALUATION/TRANSITION/FOLLOW-UP

The purpose of the evaluation process is to assure the implementation of the integration programs and services are appropriate to the participants and the community. Also, follow-up or transitional plans are developed with each participant to assure their continued placement in NSSRA, member district and community-at-large recreation programs and services.

INTEGRATION LEVELS

The identified program alternatives are determined through the assessment of each individual, and are dependent upon the amount and type of assistance and resources provided to the individual by NSSRA. An individual recreation plan identifies recommended activities and integration strategies. Participants' abilities and the nature of activities are such that the level of integration may vary so at any one time a participant may simultaneously be in programs at the first integration level and the fourth level.

Level 1

This level represents total or complete integration into recreation programs. At this level, NSSRA assists the individual by:

- Providing information on, and referral to, programs and services in participants' respective communities.
- Providing information on, and access to, registration and participation requirements.
- Being available to advise leaders of program in which the individual chooses to participate.
- Being available to observe participation and make recommendations.
- Updating and filing an IRP with NSSRA and appropriate referral agencies.
- Maintaining contact with the individual and referrals to assure program continuity and transition.

Level 2

At this level, integration is supported by NSSRA assistance and resources. NSSRA assists the individual by:

- Identifying available assistance and resources to include, but not be limited to, accessibility, transportation, and financial assistance; personnel training; equipment modifications, and resource persons such as interpreters.
- Providing leaders of programs in which the individual chooses to participate with supportive resources and information.
- Conducting periodic observations/assessments to maintain an updated IRP at NSSRA.
- Maintaining contact with the individual and referrals to assure program continuity and transition.

Level 3

At this level, integration is supported by an NSSRA trained and supervised companion. NSSRA further assists the individual by:

- Selecting, training, supervising, and evaluating the companion.
- Assisting the program leader with developing, implementing, and evaluating activities.
- Periodically observing and assessing the participant and companion to evaluate performance of both, and monitor an updated IRP.
- Maintaining contact with the individual, program leader, and companion to assure program continuity and transition.

Level 4

At this level, the participant is encouraged to become involved in NSSRA programs supportive of community integration. NSSRA makes program placement recommendations by:

- Reviewing the participant's annual information form (AIF).
- Assessing the participant's leisure interests/preferences.
- Utilizing participation criteria to recommend activity appropriateness with each individual.
- Selecting goals/objectives appropriate to each participant.
- Documenting each participant's progress and making suggestions on program alternatives.

NSSRA STAFF
INTEGRATION PROGRAM EVALUATION

Program Name: ________________________ No.: ______ Date: ______

Leader: ____

Part-time Staff: ____

Volunteers: ____

Total Enrollment: ____________ Total Participant Service Units: ____________

Total Transportation Units: ____

Directions: Check appropriate blanks and mark below either "Yes" or "No" or "Not Observed" for each listed criterion.

1. Program

Overall program operation: Inadequate _____ Somewhat Adequate _____ Adequate _____

	Yes	No	Not Observed
Were integration program goals met?	______	______	________
Was program schedule appropriate for participant?	______	______	________
Were selected activities appropriate to integration program?	______	______	________
Were integration accommodations compatible with program operation?	______	______	________
Was family/guardian response/support appropriate?	______	______	________
Were adaptions/modifications appropriate to participants with and without disabilities?	______	______	________

Comments: (include unanticipated happenings). ________________________________

____

____

2. Resources

Overall resource quality: Inadequate ________ Somewhat Adequate ________ Adequate ________

	Yes	No	Not Observed
Were resources appropriate for activities?	____	____	____________
Were safety rules posted and reviewed?	____	____	____________
Were resources safe and accessible?	____	____	____________

Comments: ____

____

____

3. Participants

Overall participant response: Inadequate ________ Somewhat Adequate ________ Adequate ________

	Yes	No	Not Observed
Was participant skill level appropriate			
to program goals and objectives?	____	____	____________
to activities?	____	____	____________
Was participant behavior appropriate for			
activities?	____	____	____________
for other participants?	____	____	____________
toward staff?	____	____	____________
Did participant enjoy activity?	____	____	____________
Will participant continue activity in other community settings?	____	____	____________
Were responses of participants with and without disabilities appropriate to one another?	____	____	____________
Was participant socially ready and prepared for experience?	____	____	____________
Was participant response and involvement in activity socially appropriate?	____	____	____________

Comments: ____

____

____

4. Leadership

	Inadequate	Somewhat Adequate	Adequate
Overall performance of leaders:	_____	_____	_____
Specialist:	_____	_____	_____
Part-Time:	_____	_____	_____
Volunteers:	_____	_____	_____

	Yes	No	Not Observed
Were leaders adequately prepared to accommodate individuals with disabilities?	_____	_____	_____
Were rules, regulations, safety procedures followed?	_____	_____	_____
Were participants' needs and behaviors managed appropriately?	_____	_____	_____
Were leaders knowledgeable of participants' abilities and implications of disability on participation?	_____	_____	_____
Was leader-participant ratio adequate?	_____	_____	_____

Comments: ____

____

____

5. Issues or Concerns
(encountered in program that have not already been addressed)

____

____

6. Program Recommendations

What suggestions would improve future integration experiences?

Program: ____

Leadership: ____

Resources: ______________________________

Training and Accommodations: ______________________________

____

____

____

____

____

____

______________________________ Staff Signature

______________ Date:

HOST AGENCY LEADER/INSTRUCTOR EVALUATION

Program/Agency: ____

Instructor Name: ____________________ Phone: ______ Evaluation Date: __________

Address: ____ Zip: ________

Rate each criteria as to its appropriateness for individuals with disabilities who were integrated into program activities.

	Very Inapprop. 1	Inapprop. 2	Somewhat Approp. 3	Very Approp. 4
Program Schedule				
1. Time of day, day of week, and length of each program session				
2. Length of entire program session and number of programs offered during the season				
Equipment and Supplies				
1. Resources and equipment usable by all program participants				
2. If made, adaptions were appropriate to individuals both with and without disabilities				
Site and Facility				
1. Facility accessible and usable by individuals with disabilities				
2. Facility was safe and maintained				
Program Operation				
1. Ability levels of all participants were compatible with program goals				
2. Activities selected were appropriate to participants' goals				
3. Integration accommodations were compatible with program operation				
Personnel				
1. Response of persons without disabilities to persons with disabilities				
2. Staff to participant radio				
3. Other staff within agency support for integration				

4. NSSRA staff orientation, training, information
5. NSSRA cooperation and direction
6. Family/guardian response and support

Do you have any suggestions or ways the NSSRA staff could improve/increase integration opportunities within the community? ______________________________

____

____

____

PARTICIPANT EVALUATION FORM

Program: ______________________ # _____ Date: __________

Season: ______________________ Site: ______________________

Participant Personal Information: (optional)

Name: ______________________ Age: ____ Phone: __________

Address: ______________________ Zip: ________

Please help us evaluate our programs by answering the questions below. Your feedback is needed to help us serve you better. Please indicate how strongly you agree or disagree with each statement by circling the appropriate rating according to the scale below:

A	B	C	D
Strongly Disagree	Disagree	Agree	Strongly Agree

All individuals' responses will remain anonymous and will only be used in a summarized form. Please feel free to make additional comments in the space provided. Return this form to the program leader for that program you attend or mail it to NSSRA. Thank you for your help!

	Rating			
A. General Program Concerns				
1. I enjoyed this program because of the development of my skills and abilities	A	B	C	D
2. I liked this program because of the chance for physical exercise it provided	A	B	C	D
3. I liked this program because of the opportunities for social contact it provided, i.e., making new acquaintances or enjoying regular contact with existing friends	A	B	C	D
4. My skills were appropriate for the program activities	A	B	C	D
5. My personal goals for participating in this program were fulfilled	A	B	C	D

B. Specific Program Concerns

1. The facility or setting in which it was held was safe and appropriate for the activity A B C D
2. The cost of the program was reasonable A B C D
3. The equipment and supplies were adequate and appropriate for the activity A B C D
4. The staff interacted with participants and provided an adequate amount of leadership and supervision A B C D

C. Integration Accommodations (Rate only statements that apply to you)

1. Information/referral was correct and adequate A B C D
2. Training of instructor prepared instructor to appropriately adapt program A B C D
3. Financial assistance was sufficient A B C D
4. Transportation was reliable and adequate A B C D
5. Equipment and facilities were appropriately modified A B C D
6. Interpreter or other communication assistance was adequate and appropriate A B C D
7. Volunteer buddy was responsive and provided needed advice/assistance A B C D
8. Parent/guardian training/contact was sufficient A B C D

D. Additional Comments: ______________________________

____

____

____

Appendix D

SAMPLE CONTENTS FOR A VOLUNTEER MANUAL FOR THE DIVISION OF THERAPEUTIC RECREATION

VOLUNTEER PLACEMENT PROCEDURES

1. A volunteer brochure will be sent out to all prospective volunteers. This year, the Division is varying the ages of volunteers for different programs. All individuals who work teen/adult programs must be 18 or over. For programs that include younger children, the minimum volunteer age will be 16. For programs that go on field trips, volunteers will be expected to provide their own transportation.

2. Specific volunteer job descriptions are written for the various program formats (e.g., aquatic, trimnastics, bowling) to give the volunteers a more specific idea of what their specific program responsibilities will consist of.

3. All program directors must have a volunteer application on each and every volunteer before they will be permitted to work the program (even if they are only going to come one time). Emergency numbers and release signatures (for individuals under 18) are IMPORTANT and must be readily available.

4. Since the program directors are the direct supervisors of the volunteers, they are responsible for their training, supervision, and evaluation. The volunteer coordinator will assist in all areas. All new volunteers must attend a training/orientation session with their program director before they will be permitted to work the program. Each volunteer should set up a time to go over this information with the program director (can be before or after program or at another time to be decided by the director and volunteer). A volunteer orientation checklist will outline the information to be included in this training session. At this time volunteer manuals will be handed out, volunteer contracts signed, and "volunteer skill bank" forms filled out.

5. All volunteer information (name, address, phone number, emergency number) should be reported to the volunteer coordinator to be put on a master volunteer list at the office. As soon as the names are turned in, a volunteer name tag will be issued.

6. Volunteer hours need to be recorded daily on the volunteer time sheet in/out log. These hours need to be turned in to the coordinators on a monthly basis. All individuals who help out at your program need to be included on this log (even if they only come once). Be sure and put first and last names and total the hours. An ongoing month by month tab of volunteer hours is included in your notebook so that each director can total the number of volunteer hours completed in a particular season. Each director can appoint an assistant

director to handle this record keeping, but the program director is responsible for its accuracy.

7. Volunteer evaluations need to be done on the volunteers after each season. Mid-season evaluations should be done verbally by the program director so the volunteers know how they are doing and what areas need improvement. The written evaluation (which is due at the end of the 10-week session) should also be completed by the program director. These evaluations only need to be filled out for volunteers who come to at least 8 out of the 10 week program sessions.

8. Volunteer recognition - volunteer hours are compiled from season to season with recognition as follows:

    25 hours - T-shirt
    75 hours - letter to school or employer
    100 hours - framed certificate, movie pass
    150 hours - plaque

9. Volunteer dismissal - no volunteer can be dismissed without approval from the program coordinator following appropriate evaluations.

VOLUNTEER APPLICATION

Name: ____________________ Male: _____ Female: _____

Address: ____________________ Zip: _______ Phone: __________

Age: _____ Date of Birth: ____________________

Representative of: ______________________________
(company or school)

PROGRAM CHOICES

Program:
Mentally Handicapped _____ Physically Handicapped _____ Learning Disability _____

Location: ______________________________

Time Available: ____________________ Days: ____________________

EDUCATION

Elementary/Junior High School: ______________________________

High School: ____________________ Years Completed: _______

College/University: ____________________ Years Completed: _______

Degree: ____________________ Year: _______ Major: ______________

Classes relating to recreation, physical education, or special education: ______________

____

____

Work experience with mentally retarded and/or physically handicapped or other special populations. Please list length of time, place of work, age group, and disability.

____

____

Other work experiences relating to recreation: ______________________________

____

Do you hold a current Lifesaving Certification?_______ Water Safety Certificate? _________
Adapted Aquatics Certification? _________ CPR (cardiopulmonary resuscitation)? ________
First Aid Certificate? _________

Please list the activities in which you have interest and knowledge such as nature, gardening, drama, dancing, music, crafts, sports, or other activities. ____________________________________

____

____

Have you volunteered with the Cincinnati Recreation Commission before? ____________

If yes, with what program? ______________________________________

How did you find out about our Therapeutic Recreation programs?

____
(newspapers, friends, radio, television, etc.)

RELEASE (MUST BE SIGNED)
I hereby assume complete responsibility for any injury or damage sustained by the applicant and release the Cincinnati Recreation Commission of any and all liability for such injury or damage occurring during volunteer work for the Cincinnati Recreation Commission.

Signature: ______________________________
If under 18, signature of a parent or guardian is required.

Person to call in case of emergency:

Name: ____

Address: ______________________________ Phone: ______________

VOLUNTEER ORIENTATION CHECKLIST

____ 1. Discuss the Division of Therapeutic Recreation--who we serve and how programs are set up on a seasonal basis (use program brochure, volunteer brochure).

____ 2. How the Division of Therapeutic Recreation is set up (use organization chart).

____ 3. Policies and procedures of the divison that volunteers must abide by (dress code, notification of absence, no smoking, no leaving the program site for lunch, no physical punishment, confidentiality).

____ 4. Discuss your individual program (program goals, participants, disabilities involved, skill levels); show volunteer program goals and skill level descriptions.

____ 5. Discuss volunteer job description for your individual program.

____ 6. Discuss importance of safety of participants at all times (go over dealing with seizures and specialized equipment such as wheelchairs, etc. where applicable). This information is found in volunteer manual.

____ 7. Discuss recordkeeping of volunteer hours (sign in/out sheet), recognition of volunteers, and volunteer evaluation. Give volunteer copy of volunteer evaluation (point out that volunteer must attend 8 out of 10 seasonal programs to be evaluated).

____ 8. Go over volunteer contract and sign. This contract should be kept with volunteer application in notebook. Need two copies (one for notebook and one for volunteer).

____ 9. Be sure volunteer has submitted an application to be kept in your notebook. If volunteer is under 18, release must be signed by parent.

____ 10. Be sure volunteer has numbers to call to notify you of absence (staff and office number)

____ 11. Give volunteer manual to volunteer.

____ 12. Fill out following volunteer information to be put on master office list:

Name: ______________________________ Phone Number: ____________

Who to contact in case of emergency: ____________________ Phone Number: ____________

As soon as this sheet is completed and turned into program coordinator, volunteer will be issued a name tag which should be worn at all times.

This volunteer orientation was held on ____________ from ____________ to ____________
date time time

______________________________ ______________________________
Signature of Program Director Signature of Volunteer

VOLUNTEER RESPONSIBILITIES

Under the supervision of the program director and/or assistant directors, volunteers in a therapeutic recreation program are responsible for assisting with or leading a variety of activities and supervision of participants.

The volunteer is responsible for:

1. Assisting in monitoring the safety of program participants, visitors, supplies, and equipment.

2. Assisting in planning diversified leisure activities based on the needs and interests of the participants according to the continuum method.

3. Notifying program director (at home or work) in case of absence. (Call one day or evening ahead, if possible.)

4. Attending at least one day of program each week for the entire program session.

5. Leading and/or assisting in conducting assigned activities.

6. Reporting progress and problems with participants and program to director and assistant directors.

7. Assisting with the evaluation of program and participants.

8. Dressing appropriately by wearing clothes that will allow you to be actively involved in activities (e.g., wear gym shoes and loose fitting, comfortable clothes).

9. Being enthusiastic!

10. Being dependable and adaptable to various situations.

VOLUNTEER CONTRACT

The Cincinnati Recreation Commission, Division of Therapeutic Recreation agrees:

a. To train volunteers to a level that will enable them to begin their work confidently.

b. To continue their training to whatever extent is necessary to maintain continuing competence.

c. To provide volunteers with working conditions equal to those of paid employees.

d. To make written evaluations of each volunteer's job performance at regular and suitable intervals and to provide references on request.

e. To offer volunteers promotion to more responsible jobs within the volunteer program.

f. To include volunteers in staff planning and evaluating when possible and generally promote their understanding of division workings and decisions.

The volunteer agrees:

a. To work a certain number of hours a week according to a schedule acceptable to the program director.

b. To become thoroughly familiar with the policies and procedures (written and verbal) set forth by the division for volunteers.

c. To be prompt and reliable in reporting for work and to provide the division with an accurate record of hours worked by signing in and out.

d. To attend orientation and training sessions and undertake continuing education as necessary to maintain competence.

e. To respect the function of the program director and staff and to contribute fully to a smooth working relationship between staff and volunteers.

f. To accept the division's right to dismiss any professional volunteer for poor performance, including poor attendance.

g. To notify the division at least one week in advance of resignation or requested leave of absence.

h. To exercise caution when acting on the division's behalf and to protect the confidentiality of all information relating to the division and its participants.

Program Director	Date	Volunteer	Date

VOLUNTEER EVALUATION FORM

DIRECTIONS: This evaluation form is to be completed one week prior to the end of the program for all volunteers working 20 program hours or more. The evaluation is to be completed by all program directors supervising the volunteer or the director supervising the volunteer for the majority of service hours. This evaluation form must be filled out in duplicate (volunteer copy and office copy).

Name: ____________________

Address: ____________________ Zip: __________

Phone: ____________________ Birthdate: ____________________

Program(s)	Director(s)	Days	Times

Rating Scale:

(4) ALWAYS (exceeds requirements)	(3) USUALLY (meets requirements)	(2) SOMETIMES (needs improvement)	(1) NEVER (unsatisfactory)

I. VOLUNTEER RESPONSIBILITIES

Program	Responsibilities	Rating
1. __________	A. __________	__________
	B. __________	__________
	C. __________	__________
2. __________	A. __________	__________
	B. __________	__________
	C. __________	__________
3. __________	A. __________	__________
	B. __________	__________
	C. __________	__________

II. ATTENDANCE

	Program	Number of Days Attended	Total Hours
1.	____________	____________	______
2.	____________	____________	______
3.	____________	____________	______

a) Total number of hours served _____

b) Number of excused absences _____

c) Number of unexcused absences _____

	4	3	2	1
d) Reports to program at scheduled time				
e) Stays through scheduled time				

Comments: ____

____

III.WORK HABITS

	4	3	2	1
a) Contributes in the planning of program				
b) Contributes in evaluating the program				
c) Demonstrates ability to conduct group activity				
d) Demonstrates ability to relate to participants on a one-to-one basis				
e) Demonstrates awareness of safety procedures				

Comments: ____

____

IV. LEARNING ABILITY

a) Knows when to ask for help and is able to follow through	4	3	2	1
b) Understands and retains training without continued supervision	4	3	2	1
c) Displays a grasp of knowledge of disabilities	4	3	2	1
d) Demonstrates an understanding of the goals of the program and the participants	4	3	2	1
e) Suggests appropriate activities for the needs, abilities, and objectives of the participants	4	3	2	1

Comments: ____

____

V. PERSONAL FITNESS

a) Dresses appropriately for program activities	4	3	2	1
b) Demonstrates physical capacity to do the job	4	3	2	1

Comments: ____

____

VI. ATTITUDE AND INITIATIVE

a) Accepts suggestions graciously	4	3	2	1
b) Displays interest and enthusiasm in work	4	3	2	1
c) Offers suggestions and introduces new ideas	4	3	2	1
d) Anticipates needs and performs without being told	4	3	2	1

Comments:

VII. INTERPERSONAL RELATIONSHIPS

a) Exhibits a personable, outgoing attitude	4	3	2	1
b) Interacts well with staff, supervisors, and other volunteers	4	3	2	1
c) Recognizes individual behavioral differences and can adjust interactions accordingly	4	3	2	1
d) Supports discipline and behavior modifications employed by program staff	4	3	2	1

Comments:

VIII. OVERALL PERFORMANCE--Please use this space for any additional information regarding job performance of volunteer.

IX. VOLUNTEER COMMENTS

____

____

____

____

____

Signature of Volunteer: ______________________ Date: __________

Signature of Evaluator(s) ______________________ Date: __________

______________________ Date: __________

______________________ Date: __________

For Office Use Only:

____

____

____

____

VOLUNTEER PROGRAM EVALUATION

NAME: ______________________________

ADDRESS: ______________________________

PROGRAM(S) VOLUNTEERED AT: ______________________________

SEASON(S) (Please Circle): Fall Winter Spring Summer

YEAR: ____________

DIRECTOR(S): ______________________________

1. How did you become aware of volunteer opportunities with the Division of Therapeutic Recreation?

____

____

____

2. Did you become involved in our programs: (a) at the beginning of the program ______
(b) mid-season ______
(c) near the end of the program season ______

3. Describe briefly what your duties were as a volunteer: ______________________________

____

____

4. Do you feel that you received adequate orientation and training before you were placed in the volunteer position? ______________________________

____

____

5. As a new volunteer, what additional skills, techniques and/or learning experiences do you feel you would benefit from: ______________________________

____

____

6. Did you find the volunteer manual to be a valuable resource? (Yes or No) ______________
Please include any information you would like to see added or covered more in depth in the volunteer manual. ______________

7. Do you feel that the responsibilities given to you as a volunteer were adequate according to your interests and abilities? ______________

8. Did you find your "on-the-job" supervision to be satisfactory? ______________

9. Do you feel that you received adequate recognition for your volunteer services?
Yes ______ No ______ COMMENTS: ______________

10. What did you like best about your volunteer experience? ______________

11. What do you feel could be improved to make your volunteer experience more valuable? ____

12. Do you plan to volunteer with us in the future? (Yes or No) ______________
If yes, would you like to be included on our volunteer mailing list? ______________

13. Would you like to be called to volunteer at the division's special events? (Yes or No) ______
COMMENTS: ______________

Designing Therapeutic Recreation Programs in the Community

Marcia Jean Carter
with
Barbara (Sam) Browne
Stephen P. LeConey
Carolyn J. Nagle

American Association for
Leisure and Recreation
an association of the
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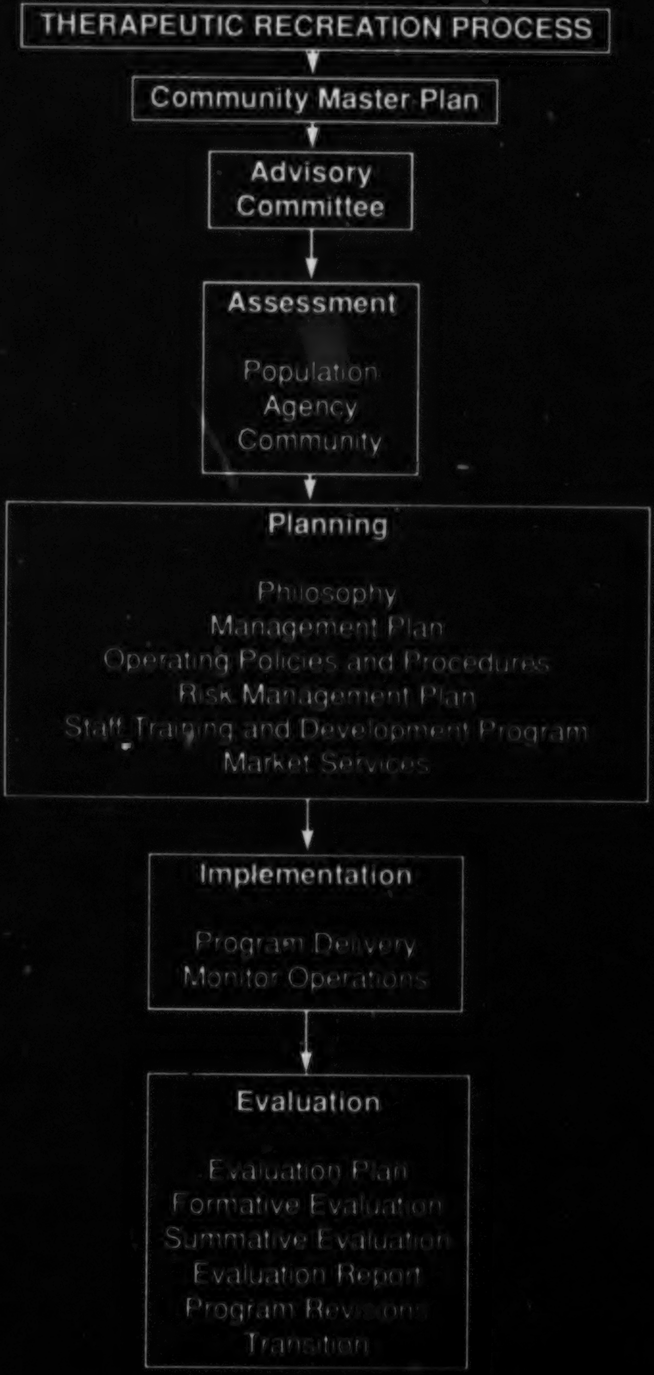
THERAPEUTIC RECREATION PROCESS
Community Master Plan
Advisory Committee
Assessment
Population
Agency
Community
Planning
Philosophy
Management Plan
Operating Policies and Procedures
Risk Management Plan
Staff Training and Development Program
Market Services
Implementation
Program Delivery
Monitor Operations
Evaluation
Evaluation Plan
Formative Evaluation
Summative Evaluation
Evaluation Report
Program Revisions
Transition

BEST COPY AVAILABLE